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Universal health coverage and the right to health

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Double issue

Editor's Note

UNIVERSAL health coverage (UHC) has become the goal of the international community since 2010 when the World Health Organisation (WHO) espoused it in its annual World Health Report. The goal received a major boost two years later when the United Nations General Assembly in a resolution urged all governments to move towards providing all people with access to affordable, quality healthcare services.

Since then, although the term has been bandied about at countless health conferences, there is still some confusion as to what UHC really means.

The term is usually treated as synonymous with 'Health for All', the vision of global health set forth by the landmark 1978 Alma Ata Declaration, which emerged from the International Conference on Primary Health Care held in the Kazakh capital. The import of the word 'universal' has fostered this belief and WHO has itself reinforced this interpretation by declaring that 'universal coverage is firmly based on … the Health for All agenda set by the Alma Ata Declaration in 1978'.

Unfortunately this conflation of the Alma Ata Declaration with the concept of UHC is misconceived. While it is true that the stated aspiration of both is to administer to the health needs of all, there are fundamental differences between the two which should not be ignored.

Despite attempts to embellish it, UHC, in its essentials, views health as a technical/administrative problem of how healthcare can be accessed without financial hardship by all who need it. The whole focus is on how health costs should be financed, with healthcare viewed as a commodity to be bought and sold.

Such a perspective almost invariably leads to the opening of the floodgates of the public health system to the untrammelled operations of private healthcare providers. Since the overarching concern is to secure healthcare at the lowest cost, opening up the public health sector to the private sector is seen as logical and necessary, given the claims of private healthcare providers that they can offer cost-effective healthcare.

To sway public opinion in favour of such opening up, the claim is also made that private healthcare providers can offer patients not only more efficient services but a freedom of choice between a range of therapies, in place of the unvariegated staple of the public health system. In our neoliberal age where 'freedom' is equated with freedom of 'consumer choice', such a claim will often prove impossible to resist. Unfortunately, when subsequently governments and consumers learn to their bitter cost that such claims are untrue or exaggerated, it may prove difficult to fix the broken health system which has resulted from pursuing such a misguided course.

The other major limitation of the concept of UHC is that health is projected as a wholly medical issue. While there is no denying the importance of medicines and medical care in ensuring the health of a community, this tunnel vision of health may shunt a country's health system into an excessive emphasis on medicalisation – a course which will no doubt be promoted by the big pharmaceutical and healthcare provisioning companies anxious to sell their products.

For developing countries, such a course is not only misguided but costly as well, given their limited resources. Ironically, although the professed central concern of UHC is to avoid 'catastrophic health costs' for those accessing healthcare, this may yet be an unintended consequence if medicalisation is allotted a disproportionate role in the health system.

All this points to the central weakness of the concept of UHC. By narrowly focusing on health as a technical/administrative matter, it ignores the fact that health is ultimately a political issue which cannot be effectively addressed without tackling its social and economic determinants. The Alma Ata Declaration recognised that health is a social goal 'whose realisation requires the action of many other social and economic sectors in addition to the health sector'. Such a holistic approach to health is singularly lacking in UHC.

Despite its limitations, the call for UHC has generally been accorded a favourable reception by international civil society. This somewhat uncritical acceptance of UHC can only be explained by the historical context in which it has emerged. The 1978 Alma Ata Declaration, with its advocacy of primary healthcare and its call for 'Health for All', raised enormous hopes of a new era in global public health. For some years, these hopes seemed fully justified with some positive outcomes in primary healthcare in countries as far afield as Nicaragua and Mozambique.

However, soon the assault on primary healthcare began, with the World Bank and the International Monetary Fund (IMF) leading the pack. The debt crisis of the 1980s allowed these institutions to gain a stranglehold on the economies of many indebted developing countries which had turned to them for loans. Under the conditionalities imposed for these loans, the debtor countries were obliged to drastically slash their public sector expenditure, including on healthcare. The decimation of the health services of these countries continued apace in the 1990s with the ideological ascendancy of neoliberalism and its strictures on public expenditure. After decades of austerity and broken health systems, is it any surprise that UHC, with its overtones of 'Health for All', should be so warmly welcomed?

Yet for all that, health activists must continue to maintain a critical stance on UHC. If the right to health is to be truly realised, it must be placed on more secure foundations.

Our cover story interrogates the concept of UHC and shows up its limitations. In addition, we also present several case studies of healthcare and health crises in a number of countries and regions. Hopefully some useful lessons can be learnt from their experiences.

– The Editors

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WHO/Fernando G Revilla

'Universal health coverage' has been espoused as a panacea for meeting health needs of developing countries, but what does it entail in practice?

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The end of an illusion: biodiversity conservation through bilateral bioprospecting

There are worthwhile lessons for other countries to be learnt from Costa Rica's ill-advised decision to permit a private non-profit institute to manage Latin America's second largest natural history collection, says *Edward Hammond*.

The National Biodiversity Institute (INBio) of Costa Rica has transferred its biodiversity collections to the government.

AFTER an extended financial crisis and lengthy negotiations, Costa Rica's National Biodiversity Institute (INBio) is transferring its land and biodiversity collections to the government. Shedding its major assets, INBio will continue as a non-governmental entity in a smaller form, offering biodiversity consulting and bioprospecting services.

It is a sobering fall from grace for an Institute that once assumed control of the nation's natural history collection, maintained a prominent international profile, and suggested its bioprospecting deals could earn more than $300 million per year for the small country. Although INBio was frequently lauded internationally, to the disappointment of many Costa Ricans it was never able to deliver on its domestic economic promise and ultimately was unable to support itself.

The asset transfers will save the country's biodiversity collections, which INBio could no longer pay to maintain, by returning them to government control. These formally changed hands on 27 March at a ceremony where INBio, perhaps seeking to ease tensions, announced the naming of two newly discovered species after government officials.[1]

Beyond the drama that has surrounded the fate of Latin America's second largest natural history collection, INBio's financial meltdown has raised questions about the prominent role that it was allowed to play in overseeing Costa Rica's natural national patrimony. Although it is a non-profit private entity, INBio was permitted quasi-statal roles, past decisions that are now coming under greater scrutiny.

Also raising questions is the failure of INBio's bioprospecting programme, once seen as an international model and a rising economic engine for conservation, but which ultimately offered up access to Costa Rican biodiversity to foreign companies at a low rate of return and, INBio's critics say, without needed transparency.

One of INBio's founding purposes in 1989 was 'integrating national [biodiversity] collections into one physical and administrative entity', namely INBio itself.[2] Controversial from the start, this activity drew resistance from government scientists as soon as it began, as INBio sought to remove collections from the National Natural History Museum.[3]

Today, however, INBio is unable to pay the cost of maintaining the national biodiversity collections it tends, which number 3.5 million items and are estimated to cover nearly a third of Costa Rica's biodiversity. The specimens will pass to the National Natural History Museum, which will assume the cost of maintaining them but which is under pressure from foreign scientists to maintain the same easy access that INBio offered,[4] and has confronted claims by INBio that elements of the database that indexes the national collection are INBio's private intellectual property.[5]

The government has purchased INBio's other major tangible asset, INBioparque, a suburban theme park built to educate Costa Ricans and tourists about biodiversity. It is planned to be the site of new offices for SINAC, the agency that manages Costa Rica's protected areas. Title to the park has been transferred to the government, and INBio recently contracted to administer the facilities through March 2016.[6]

INBio's bioprospecting programme ultimately offered up access to Costa Rican biodiversity to foreign companies at a low rate of return and, critics say, without needed transparency.

It was supposed to be the other way around. INBio collected biodiversity samples in SINAC-administered protected areas and was to support SINAC by paying the agency 50% of the Institute's bioprospecting royalty income.[7] The income never materialised and, instead of receiving royalties, SINAC's parent ministry is now paying to buy INBio's land, offering a lifeline to the cash-strapped Institute, but at a cost that environment ministry officials say they cannot afford.[8]

The bilateral model does not work

INBio was one of the first groups to promote and implement the bilateral bioprospecting model widely touted in the early years of the United Nations Convention on Biological Diversity (CBD). It aimed to link developing-country conservation and research institutions with Northern companies eager to exploit what was then termed 'green gold' (i.e., the commercial potential of tropical forest species) through bilateral bioprospecting contracts.

In the model, in return for providing access to sovereign biodiversity, developing countries would be paid small up-front fees and then larger royalties once products were patented and commercialised. INBio also hoped to garner jobs processing natural product ingredients. Bioprospecting patent royalties, the model promised, could be directly invested in conservation, such as protected areas, and related science, such as taxonomy.

INBio's most famous deal was a 1991 agreement with drug company Merck, made even before the CBD was signed at the 1992 Earth Summit in Rio de Janeiro, Brazil. At the Earth Summit and afterwards, the Merck-INBio deal was hailed as a harbinger of a new era for rainforest-derived drugs, poised to yield large financial benefits for developing countries. The Merck deal continued to be cited as a 'success' into the 2000s, although by 2008 Merck walked away from the agreement and, in 2011, gave away its library of natural compounds, in the view of one commentator 'as if to mark the [20th] anniversary of its Costa Rican folly'.[9]

Although INBio continues to be enthusiastically lauded by Northern foundations and companies, most recently winning a 2014 award from Japan's Asahi Glass Foundation,[10] the economic reality of its bioprospecting programme was not nearly as positive as the extensive attention it received from the grantors of international prizes.

INBio's Merck deal and other bioprospecting contracts failed to generate enough revenue for the Institute itself to be economically viable, much less the 10-20 major new pharmaceuticals, large contributions to national parks, and 'more income to the country than the $300 million we normally get from coffee [annually]' that INBio leaders initially suggested were possible.[11] (Accounting for inflation, that's over $500 million a year today.)

The state bails out INBio amidst criticism

Recently, sources of revenue for INBio have included the administration of aid funding – a Global Environment Facility (GEF) small grants programme – although the government has recently rescinded INBio's authority to do so.[12]

Some Costa Rican critics question why the state should keep the Institute alive by buying its money-losing biodiversity theme park, and if the price is too high.

The deal to buy INBioparque calls for the government to pay almost 5 billion Costa Rican colones ($9.35 million) for 7.2 hectares of land, about two-thirds of which are undeveloped. The housing ministry made an initial

payment of $2.8 million, with additional instalments due over the course of several years. Environment ministry officials, however, who are on the hook to make those payments, have expressed concern. The nearly $1 million per year for the next six years, they say, is too large a proportion of the ministry's budget.[13]

The transfer of INBio's biodiversity collection has also prompted criticism. INBio initially sought to characterise it as a gift to the nation, a view that Costa Rican scientists did not share. In 2013, when outlines of the deal became public, the former director of the Natural History Museum, Melania Ortiz Volio, pointed out that the role of curating the biodiversity collections had been taken away from the Museum in 1989, when INBio was founded, because the private entity would allegedly do a better job. Yet INBio had proven financially unstable and sought to return responsibility to the state.

'The irresponsibility is incredible,' an obviously incensed Ortiz Volio wrote in an editorial, 'as was the initial arrogance, and two decades later, in bankruptcy, they hand over everything for the State to pay.'[14] (INBio has not technically entered bankruptcy but has been unable to pay its bills. INBio management has termed the process 'expropriation by mutual agreement'.)[15]

Other Costa Rican biologists have been similarly critical, noting that INBio benefited from numerous confidential bioprospecting agreements without a public accounting, which they juxtapose against the efforts of indigenous peoples, local communities and other non-governmental organisations to develop Costa Rica's biodiversity law, which has access and benefit-sharing provisions. 'INBio is giving back what never belonged to it,' they write, referring to the biodiversity collections, saying that they could have been put to better use over the past two decades supporting protected areas rather than INBio itself.[16]

INBio intends to press forward in a pared-down form that it likens to a 'think-tank', with its website offering training, consultancy and bio-prospecting services. Some of INBio's expertise is sure, for instance in Costa Rican taxonomy and public biodiversity education, but with the Institute's recent calamitous past and uncertain domestic relationships, it remains to be seen how many clients will be forthcoming.

Lessons from the INBio failure

While limited financial resources and the urgency of biodiversity conservation seldom allow policy-makers the luxury of extensive retrospection, there are worthwhile lessons for other countries to be learnt from INBio's fate. In retrospect, the Costa Rican government's late 1980s and early 90s decisions to permit a new, private entity to wield such strong control over national patrimony and policy-making appear to have been mistakes.

To many observers, it has also been apparent for a number of years that INBio's bioprospecting model, implemented at the dawn of the CBD, and similar approaches applied elsewhere, have failed to yield the anticipated benefit-sharing. But the general approach has been slow to evolve or be replaced. Here, INBio's fate should add underscore and exclamation point to the conclusion that bioprospecting schemes reliant on pharmaceutical patent royalties are quite likely to fail, even if the developing-country partner(s) have strong self-interest, domestic legal tools and sophisticated negotiation skills. ◆

Edward Hammond directs Prickly Research (www.pricklyresearch.com), a research and writing consultancy based in Austin, Texas, USA. He has worked on biodiversity and infectious diseases issues since 1994.

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UN rights expert denounces secret talks on trade treaties

As protests mount against free trade and investment treaties, particularly those like the Trans-Pacific Partnership which are being negotiated in secret, a United Nations rights expert has called for a human rights impact assessment to be urgently undertaken. *Kanaga Raja* reports.

A UNITED Nations rights expert has expressed deep concern over the general lack of awareness of the adverse effects that existing bilateral and multilateral free trade and investment agreements, or those under negotiation, have on the enjoyment of human rights, particularly in the developing countries.

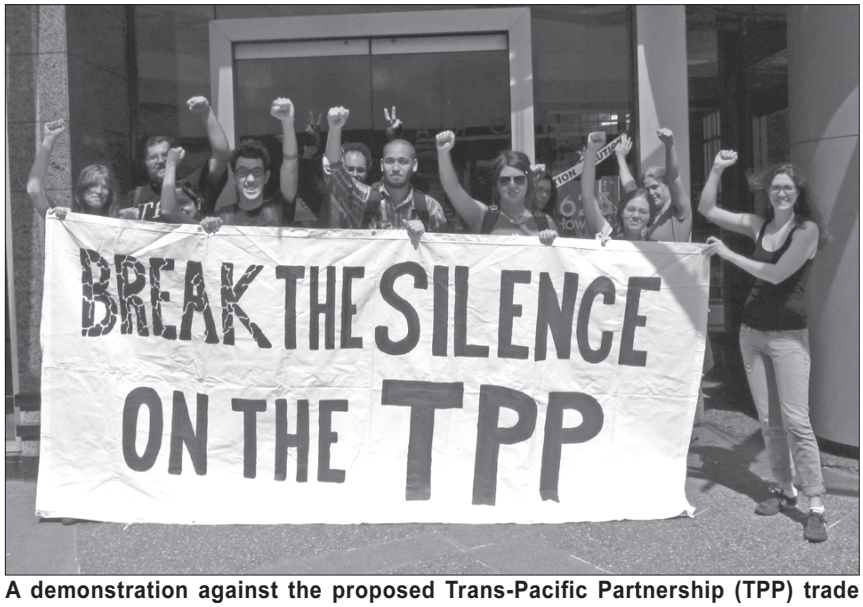
The UN Independent Expert on the promotion of a democratic and equitable international order, Alfred de Zayas, who is from the United States, said that he is concerned about 'the secrecy surrounding negotiations for trade treaties, which have excluded key stakeholder groups from the process, including labour unions, environmental protection groups, food-safety movements and health professionals'.

In a press release issued on 23 April, the rights expert emphasised that proactive disclosure by governments, genuine consultation and public participation in decision-making are indispensable to make these agreements democratically legitimate.

De Zayas warned that 'fast-tracking' adoption of such treaties has a detrimental impact on the promotion of a democratic and equitable world order.

'It is tantamount to disenfranchising the public and constitutes a violation to accepted human rights law, which stipulates that every citizen shall have the right and the opportunity to take part in the conduct of public affairs,' he said.

The expert underlined that there is a general lack of awareness concerning the adverse effects that existing bilateral and multilateral free trade and investment agreements already have on the enjoyment of human rights, including the right to health, the right to education and the right to live in a safe, clean, healthy and sustainable environment.



A demonstration against the proposed Trans-Pacific Partnership (TPP) trade agreement. A UN rights expert has said that proactive disclosure by governments, genuine consultation and public participation in decision-making are needed to make trade accords democratically legitimate.

Investor-state arbitrations

The UN expert called for human rights impact assessments to be urgently undertaken, given the numerous treaties currently under consideration and the potential risk they represent for the enjoyment of human rights.

'I am especially worried about the impact that investor-state arbitrations [also known as investor-state dispute settlement – ISDS] have already had and foreseeably will have on human rights, in particular the provision which allows investors to challenge domestic legislation and administrative decisions if these can potentially reduce their profits,' he said.

The rights expert pointed out that such investor-state tribunals are made up of arbitrators, mostly corporate lawyers, whose independence has been put into question on grounds of conflict of interest, and whose decisions are not subject to appeal or to other forms of accountability.

De Zayas also pointed out that the apparent lack of independence, transparency and accountability of ISDS tribunals entails a violation (prima facie) of the fundamental principle of legality laid down in international human rights law, including Article 14 of the International Covenant on Civil and Political Rights (ICCPR), which

requires that suits at law be adjudicated by independent tribunals.

It has been argued that ISDS tilts the playing field away from democratic accountability, favouring 'big business' over the rights and interests of labourers and consumers, he said.

The rights expert further underlined that the establishment of parallel systems of dispute settlement and their exemption from scrutiny and appeal are incompatible with the principles of constitutionality and the rule of law, and as such are harmful to the moral welfare of society ('contra bonos mores').

'Because all States are bound by the United Nations Charter, all bilateral and international treaties must conform with the Charter and its principles of equal rights and self-determination of peoples, respect for human rights and fundamental freedoms, sovereign equality of States, the prohibition of the threat of and the use of force and of intervention in matters which are essentially within the domestic jurisdiction of States.'

According to the rights expert, Article 103 of the UN Charter clearly stipulates that provisions of free trade and investment agreements as well as decisions of ISDS arbitrators must conform with the Charter and must not lead to a violation, erosion of or retrogression in human rights protection or compromise state sovereignty and the state's fundamental obligation to ensure the human rights and well-being of all persons living under its jurisdiction.

(Article 103 states that 'in the event of conflict between the obligations of the Members of the United Nations under the present Charter and their obligations under any other international agreement, their obligations under the present Charter shall prevail.')

'Agreements or arbitral decisions that violate international human rights law are null and void as incompatible with Article 103 of the UN Charter and contrary to international ordre public,' de Zayas said. ◆

Kanaga Raja is Editor of the South-North Development Monitor (SUNS) *published by the Third World Network. This article is reproduced from* SUNS *(No. 8010, 27 April 2015).*

Universal health coverage: the rhetoric and the substance

Universal health coverage (UHC) is now being held out as the solution to the pressing problem of providing healthcare to the millions in developing countries. But what does UHC really imply? *Amit Sengupta* unpacks the concept.

PROPONENTS of universal health coverage (UHC) have termed it the 'third great transition' in health that is changing how healthcare is financed and how health systems are organised.[1] Given the very wide consensus which appears to have emerged in the health and development sector, that the attainment of UHC is the solution to the very acute and pressing problem of compromised access to healthcare in low- and middle-income countries (LMICs), it is important to unpack the concept of UHC.

Scene at a hospital waiting room in Egypt. Universal health coverage has been conceived as a health financing system that would progressively move towards coverage of the entire population; the centrality of public healthcare services is not a part of this narrative.

One of the early occasions when UHC was mentioned as an overarching concept in an international platform was its inclusion in a resolution adopted at the 58th World Health Assembly in 2005. Titled 'Sustainable health financing, universal coverage and social health insurance', the resolution, inter alia, called upon member states to 'ensure that health-financing systems include a method for prepayment of financial contributions for healthcare, with a view to sharing risk among the population and avoiding catastrophic healthcare expenditure and impoverishment of individuals as a result of seeking care'.

UHC arose as a method of ensuring sustainable financing for health and not with a view to addressing the precise mechanism by which healthcare would be provided. Rather, the key concern that was sought to be addressed was avoidance of catastrophic healthcare expenditure. This raises the rather obvious question: why were populations in many parts of the world faced with a situation where they were forced to incur 'catastrophic'[2] expenditures on healthcare? The answer lies in the manner in which global policies impacted upon health services in LMICs.

Undermining of healthcare services

Healthcare systems need to be adequately financed and resourced with trained human-power. They also require the availability of basic infrastructure. The inability of low-income countries to pledge even a fraction of the resources required to sustain their healthcare systems has its origins in the economic crisis that engulfed these countries since the 1970s.

The crisis in the 1970s

The crisis had started by affecting the industrialised countries through the impact of the sudden rise in oil prices in 1973 and the resulting stagnation of industrial activity in these countries. But the impact of this crisis was transferred by the industrialised countries to the developing countries. This arose as a result of the 1979 decision by the US Federal Reserve to combat inflation by a steep and unprecedented rise in interest rates. The effect of this monetarist policy on many developing countries was visible very soon – the collapse of many of their economies. For developing countries which had taken out huge loans at extremely favourable terms to offset the shock of the oil price hike, the result was a catastrophic debt crisis, i.e., a state of bankruptcy of many developing countries which could not even pay back the interest on their loans. In desperation, many of these countries turned

to the International Monetary Fund (IMF) and the World Bank for new loans.

This crisis came within a few years of the Alma Ata Declaration – the landmark document on public health adopted by the International Conference on Primary Health Care in Alma Ata, Kazakhstan, in 1978 – and prevented its bold and visionary aspirations from ever being put into practice. Instead, the crisis translated into savage cuts in government spending on social sectors such as health and education. Government health facilities suffered greatly, leading to their virtual dismantling and severe loss of morale among public health workers.

The UHC discourse is in sharp contrast to the vision of primary healthcare envisaged in the Alma Ata Declaration adopted by the International Conference on Primary Health Care in 1978 *(pic)*.

Structural adjustment conditionalities and health sector reforms

Many of these cuts were part of 'structural adjustment programmes' forced upon countries by the IMF and World Bank as conditions attached to their loans. Not only that, the IMF and World Bank sought to promote their brand of 'health sector reforms'. The World Bank released in 1987 a paper that was to influence health reforms across the globe. With this publication, titled 'Financing Health Services in Developing Countries: An Agenda for Reform', the World Bank announced its intent to play a prominent role in global health reform. In 1993, the World Bank's World Development Report, *Investing in Health*, outlined its agenda for health reform that advocated the following:[3]

• Foster an enabling environment for households to improve health: In effect this meant that disadvantaged families were required to cover their own health costs. In other words, fee for service and cost recovery through user fees.

• Improve government spending in health: This called for trimming of government spending by reducing services from comprehensive coverage to a narrowly selective, 'cost-effective' approach or a new brand of selective primary healthcare.

• Promote diversity and competition in health services: This dealt with the turning over to private doctors and businesses of most of those government services that used to provide free or subsidised care to the poor. It implied privatisation of most medical and health services, thus pricing many medical interventions beyond the reach of those in greatest need.

The ideological legitimation for these reforms was provided by the rise of neoliberal economic policies across the globe. Neoliberal policies are based on a model of development that promotes the predominance of the market and a consequent reduction of the role of governments.

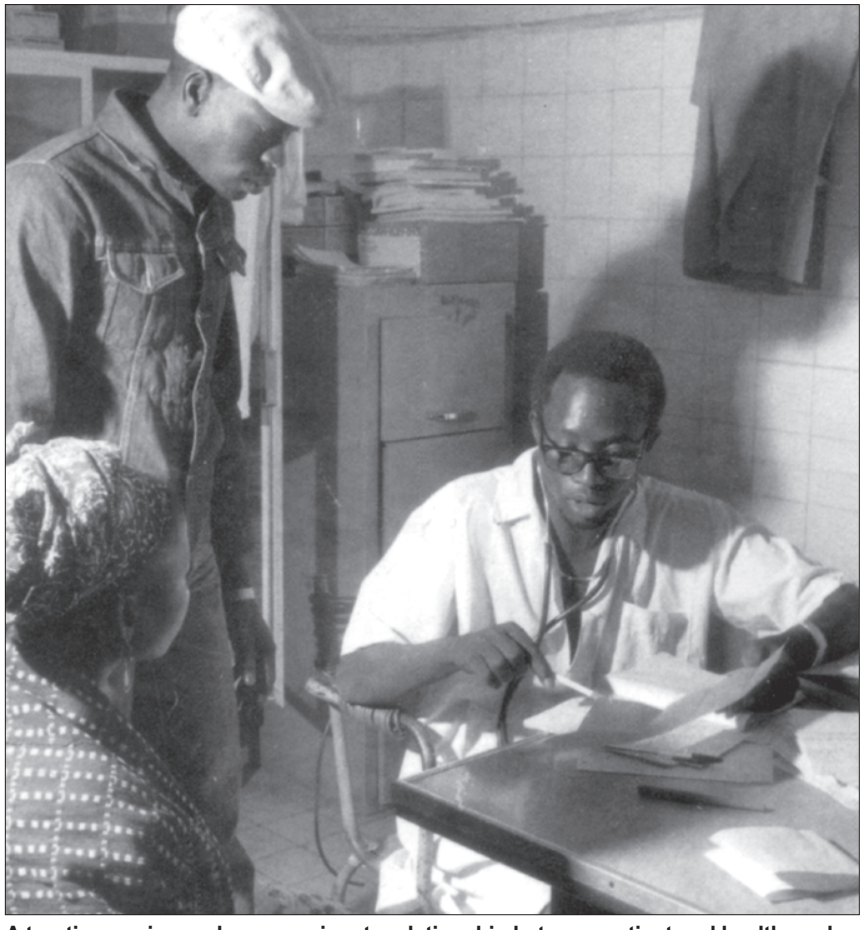
Erosion and collapse of public systems

A prominent effect of health sector reform was the promotion of greater privatisation of healthcare. This meant that people have to spend more money themselves to access healthcare. Curiously, this effect has been used as an argument to introduce systems of payment (in the form of 'user fees') in the public healthcare system as well. The logic of this argument goes: if people are already paying in the private sector, they can also pay to access the public sector! In the context of a push to decrease government spending, the attempt has also been to use such payments as a way to offset government expenditure in running the public system.

Hand in hand with the levying of user fees came the trend of segmenting healthcare into public healthcare for the poor and private healthcare for the rich. On the face of it, this seemed an attractive proposition, one that the World Bank actively propagated. Along with this, the Bank advocated that governments in lower-income countries should not attempt to provide comprehensive care but concentrate instead on providing a 'minimum' package of services targeted at the poor.[4] Segmentation was also actively promoted in middle- and high-income countries, where tax breaks on private insurance were used to entice higher-income groups away from publicly funded health services.

The argument in favour of this segmentation is obvious: government

resources can be directed at those who cannot pay, while those who can are serviced by the private sector. Unfortunately this argument is based on an extremely shallow and simplistic view of how health systems work. Such a system results in the rich opting out of the public system and at the same time also drawing away resources, political clout and accountability from the public system. An expansion of the private sector also drains resources away from the public system in different ways. It draws on a limited pool of health professionals and on limited foreign exchange for the import of drugs and equipment in developing countries. Ultimately it sucks resources away to the extent that the public system is even more hard-pressed to cope with its workload. What is left is 'a poor service for poor people'.



A trusting, caring and compassionate relationship between patient and health worker is in itself a therapeutic intervention that would be corrupted by a market-based relationship between consumer and provider.

UHC to the rescue!

By the turn of the millennium, the debate had come full circle. The impact of the Fund-Bank-driven policies was being felt in most LMICs and out-of-pocket expenses were a major component of health financing in many countries.

A possible recourse to remedy the situation could have been the promotion of efforts to rebuild public systems. This course, however, was generally not promoted as the principal way to fix the broken system. Instead the debate shifted from how services were to be provided to how services were to be financed, under the broad rubric of universal health coverage. With the gaze firmly directed at catastrophic 'expenses', the remedy proposed was one involving the securing of finances and not securing of quality health services. The logic appeared to be that if the money can be secured, provisioning of health services would take care of itself.

UHC: The proposal

It is useful to first understand clearly what was proposed as UHC. The World Health Organisation's 2010 World Health Report (WHR 2010), titled *Health Systems Financing: The Path to Universal Coverage*, elaborated this in full measure. UHC has been conceived as a health financing system that would progressively move towards coverage of the entire population, include an increasing range of services, and seek to increase the share of pooled funds as the major source of funding (in relation to co-payments by those accessing healthcare). The centrality of public healthcare services is not a part of this narrative. The role of the state is that of managing this system. The system envisaged is thus one where we see a clear 'provider-purchaser' split – the issues of financing (and management) are entirely divorced from provisioning.

It is worth noting here that such a split has been the hallmark of reforms of other public services as well. The import of this split is that theoretically, under this model, health services can be entirely provided by private enterprises while the state mediates to secure the funding of these services and regulates (to the extent possible) the quality and range of services provided by such enterprises. A provider-purchaser split puts a price on services – that is, it commodifies them, which is the precondition for their transaction in the marketplace.[5]

New public management and UHC

In fact the strategy of reform in public services since 1987 – sometimes referred to as the new public management – has been to introduce private sector management, organisation and labour market practices into the public sector in the expectation that the sector can thus be made to deliver the sorts of service and efficiency that the private sector (and its competitive environment) has supposedly already realised. More specifically, and most clearly in the areas of

health and education, there has been an aspiration to introduce 'internal markets' within the domain of public provision.

In these reforms, public funding has been retained but steps have been taken to divide the purchasers from the providers of services. The intention is that individual units (schools, colleges or healthcare trusts) should compete for consumers of their services. The purchaser of these services (parents, patients or their surrogates) should be able to move their custom between providers with relative ease. This so-called new public management is crucial to subsequent privatisation of public services, as otherwise public services in their classical form are not designed to be purchasable commodities and are therefore useless as marketable commodities.[6]

The role of public services is defined in WHR 2010 in the following manner: 'Governments have a responsibility to ensure that all providers, public and private, operate appropriately and attend to patients' needs cost effectively and efficiently.' In other words, UHC does not discriminate between public and private services, its only concerns are cost-effectiveness and efficiency. In practice, this impartial role of the state can translate into different interpretations and is also subject to the current state of public health services. With public health systems in a state of disarray brought upon by the exercise of Fund-Bank-directed policies as we have noted earlier, states can choose not to rebuild public systems but to rely increasingly on private providers. This is happening to varying degrees in most LMICs. The logic applied is: something needs to be done to rein in the catastrophic impact of out-of-pocket expenditures immediately, and as the public system is too weak to respond, it is strategic to turn to the private sector. In short, the UHC model provides the opportunity for exercising such a choice by the way it is constructed, and in situations where the state itself is committed to pursuing neoliberal policies, the choice veers away from options that are based on public systems.

Influential votaries of UHC are happy to emphasise the key role to be played by governments in strategically 'purchasing' care to improve 'efficiency', rather than any role by governments to provide services. For example, an issue of the *Bulletin of the World Health Organisation* argues: 'Countries cannot simply spend their way to universal health coverage. To sustain progress, efficiency and accountability must be ensured. The main health financing instrument for promoting efficiency in the use of funds is purchasing, and more specifically, strategic purchasing.'[7]

This discourse of UHC is in sharp contrast to the vision of primary healthcare envisaged in the Alma Ata Declaration of 1978, which called for the building of health systems that were integrated, provided comprehensive care, were organised to promote equity, and were driven by community needs.[8] UHC instead envisages healthcare as pieces of a jigsaw puzzle, connected only by a common financing pool and by regulation of an array of private and public providers.

UHC a step forward?

UHC is a step forward to the extent that it is an explicit recognition of two important aspects of public health. By prescribing a central role to the state in securing funding for healthcare and in regulating the quality and range of services, UHC recognises that 'market failures' are a feature of healthcare and patients suffer when they have to buy healthcare in a free-market situation. It also thereby recognises that health is a 'public good' with externalities, and the state has responsibility to ensure access. Again here UHC provides the possibility of exercising a choice, and relatively more progressive governments would try to privilege public systems and would be more inclined to examine funding mechanisms that promote equity. Financial pooling through UHC makes it easier to develop comprehensive public systems, but whether that will happen is subject to a political choice shaped by various factors.

It needs to be noted that 'coverage' and not 'care' is what is formally sought to be universalised under the rubric of UHC. UHC can move towards universal 'care' but it would not if 'care' is defined in narrow terms as access to a basic package of services.

Levels of ambiguities in UHC

We can perceive two levels of ambiguities embedded in the present concept of UHC. While it proposes that funding for health should be pooled, it does not propose the same for provision of services, that is, it does not propose a unified system of public provision. Further, it does not define the 'depth' of coverage and hence allows an interpretation that coverage can mean a basic package, quite akin to the World Bank's prescriptions two decades back.

These ambiguities were clearly captured by a literature survey of peer-reviewed publications on UHC. Just 21 of the 100 papers analysed provided an explicit definition of UHC. Among these, there was little consensus and the meanings were often unclear. The majority referred to UHC as universal coverage, but differed in regard to whether they meant a comprehensive set of healthcare services, whereas others referred to a single intervention.[9]

Why an integrated public system for healthcare?

There are structural reasons why market-driven healthcare and promotion of market competition does not promote efficiency or quality.[10] In other words, market competition is not inherently superior to pure or predominant public sector provision of health services.

Market competition does not make for better care as most patients do not have enough knowledge to make informed choices about the relative quality or merits of different healthcare providers, nor are they willing, able or assertive enough to negotiate on price and quality, especially when care is urgent, when sickness results in vulnerability or when illiteracy and poverty are prevalent (called information asymmetry in the

healthcare 'market'). Most people do not want 'choice' in healthcare, but an assurance that their local and accessible healthcare provider will provide good, if not the best, quality care. Instead, commercialised healthcare eats away at provider-patient trust, adding to the stress of being sick or injured. A trusting, caring and compassionate relationship between patient and health worker is in itself a therapeutic intervention that is corrupted by the market-based relationship between consumer and provider.[11]

Commercialised healthcare systems often have very high transaction costs that are necessary to manage or regulate the market. Similar cost issues accompany the management of public contracts with private providers, especially those providers motivated to maximise income, who may strive to take shortcuts or manipulate data to achieve their contract specifications at the lowest cost, even at the expense of patients and the public good. To counteract this, purchasers end up spending large amounts of money on systems designed to catch out contractees in a 'cat and mouse' game of detection and deception, or end up being drawn into costly contract disputes.[12]

Public systems are more efficient also because they ensure economies of scale in the purchasing, supply and distribution of drugs and equipment.[13] In the Indian state of Tamil Nadu, for example, pooled purchasing of medicines undertaken by a public sector entity has driven down medicine costs significantly, and other Indian states are engaged in duplicating the model.[14] Public health systems embed other levels of efficiency as well. National or district-level systems for administration, staffing and training are able to reduce management costs of multiple private providers. Further provision at scale also enables specialisation: a full range of products and services can be offered at lower cost than if provided by individual operators.[15]

Public systems perform tasks that are not directly linked to providing care. These include maintaining disease surveillance systems, providing immunisation to the entire population, as well as several other public health tasks. A public system that integrates these functions with healthcare delivery is best placed to secure better health outcomes. Public health is based on systematic applications of best-practice technologies applied at population scale and systematic monitoring and data collection. Vaccine coverage should be applied comprehensively in order to achieve herd immunity in the community. Disease eradication, such as for smallpox and perhaps imminently for polio, depends on universal protection applied systematically and rigorously. Even the control of communicable diseases not currently close to eradication, such as malaria, will often be characterised by mass action benefits if coverage levels are very high.[16]

If health systems are to provide care to a whole population, there are significant marginal costs involved in the delivery of care to the most inaccessible or the most disadvantaged sections of the population. The costs of delivering care to geographically remote or sparsely distributed populations can be much higher than the concentrated delivery of care in urban settings. Delivery of care to those with pre-existing, chronic conditions is also often more expensive, as is the treatment of rare diseases compared with common ones.[17] In an aging population a very high proportion of healthcare needs are concentrated in the last few months or years of life. Public systems can absorb these marginal costs and spread them across an entire population. Private systems, on the other hand, would find such costs to be unacceptable and would attempt to avoid care provision to people who live in underserved areas, who are disadvantaged, or those who suffer from conditions that require expensive care or long-term care. Public systems thus promote equity while even the best-designed private systems undermine equity.

Finally, competition harms collaboration between different providers, often an important ingredient of good-quality care, especially in relation to referrals between different kinds of specialists or between different levels of the healthcare system.

The argument that health systems in LMICs should leverage on the already dominant private sector is clearly misplaced. If the public sector is nearly moribund because it is deeply underfunded, the private sector will fill up the space ceded. The large out-of-pocket expenditures and private provision in low-income countries are mainly a reflection of the paucity of public services, especially for the poor, forcing the middle and upper classes to go directly to private providers, while the poor are left without reliable basic services. This reality is unfortunate, and not a case for private provision, but rather a call to action to bolster the deeply under-financed public sector.[18]

Conclusions

In our analysis, while tracing the genesis of UHC, we have discussed how UHC builds on the notion of health systems promoted by the World Bank and other global institutions – segmentation of health systems into parallel private and public systems, in which the poor are provided only 'basic services' by an underfunded public system and the rich migrate to a burgeoning private system. The logic for UHC is driven by the need to secure pooled funds for health systems that are organised on the principles of the market. The role of the state is being increasingly identified as that of a 'steward' and not a provider of healthcare services. New management techniques are being introduced in order to accomplish this, based on the notion of a 'purchaser-provider' split. The state, in such a system, harnesses public funds and then as a purchaser of services makes these funds available to private capital to extract profits. At a global level capital is seeking a new domain for profit-making, in an area earlier designated as a public good and hence not available as a marketable commodity.

We are now seeing a convergence of systems in the developed and the developing countries. Both are re-

forming existing systems and are moving away from the solidarity-based notion of healthcare to a market-based system for healthcare provision.

The present dominant model of UHC that is being promoted worldwide – based on 'universal' insurance – offers no advantages and many disadvantages over the option of a single public health system with universal and free access and financed with tax funds. This latter is the most humane option, because it values the lives of all equally; it is the most fair, because those in need receive proportionally more; it is the most equitable, because all have equal access to the available services when faced with the same need; and it is the most affordable, because it does not have to generate a profit and its administrative expenses are lower.[19]

Reforms are necessary in public systems that free them from control by a self-seeking bureaucracy that is tied to neoliberal governments. People's movements and organisations have a stake and a definite role in reclaiming public systems and in transforming them as well. The fight for a just and equitable health system has to be part of the broader struggle for comprehensive rights and entitlements. In this struggle, if UHC appears an attractive slogan, so be it, but it needs to be understood first for what it stands for in the hearts and minds of those primarily responsible for promoting the concept of UHC. ◆

Dr Amit Sengupta trained in medicine and works on issues related to public health, pharmaceuticals policy and other science and technology (S&T) policy issues like intellectual property rights. He is Co-Convenor of People's Health Movement – India and Associate Coordinator of People's Health Movement (Global). He is also associated with the Delhi Science Forum – a public interest organisation working on S&T policy issues – as well as with the All India People's Science Network.

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The seven sins and seven virtues of universal health coverage

Universal health coverage is likely to become the backbone on which the health development agenda beyond 2015 will be constructed. To avoid unintended effects, universal health coverage should keep away from committing seven sins and should try to practise seven virtues.

Adriano Cattaneo, Giorgio Tamburlini, Angelo Stefanini, Eduardo Missoni, Gavino Maciocco, Gianni Tognoni, Carlo Resti, Claudio Beltramello, Chiara Bodini and Nicoletta Dentico

BACKED by most actors in the global health scene, universal health coverage (UHC) is likely to become the mantra that will drive health transformations for years to come and the backbone on which the health development agenda beyond 2015 will be constructed. There is now widespread agreement on the need to extend access to healthcare to all individuals and populations, as illustrated by UN statements,[1] World Health Organisation (WHO) reports[2] and a number of articles in medical journals, including a *Lancet* series.[3] The call for UHC comes at a time when, after decades of neoliberal policies, privatisation of healthcare services has reached a peak, leading in many countries to further exclusion and/or catastrophic expenditures. To help reverse this trend, however, and to avoid unintended effects, UHC should keep away from committing seven sins and try to practise seven virtues.

1. Sloth (failure to do things that one should do and to make the most of one's talents and gifts) vs. Diligence (upholding one's convictions at all times, especially when no one else is watching)

To many people, UHC may sound like Health for All.[4] However, what is currently proposed differs substantially from what was proposed in Alma Ata. Primary healthcare intended to transform health systems, as opposed to healthcare systems, within a broader social transformation. The signatories of the Alma Ata Declaration were aware of the importance of the social determinants of health well before the report of the WHO Commission on the issue.[5] Primary healthcare included education, nutrition, water and sanitation, in addition to essential healthcare. Unless UHC is served with an extensive dressing of primary healthcare and social determinants of health, i.e., unless it is implemented within a framework of social and economic transformation, it will not transform health as profoundly as hoped. Paradoxically, an excessive focus on UHC could divert attention and resources from other sectors with a bearing on health.[6]

2. Greed (inordinate desire to acquire or possess more than one needs) vs. Charity (benevolent giving and caring, solidarity)

To some people, UHC may seem to be synonymous with health insurance schemes that would fund a limited package of services, with governments playing a range of different and often minimal roles. The equation of UHC with financial coverage is implied also in the title of WHO's World Health Report for 2010, *Health Systems Financing: The Path to Universal Coverage*.[7] Such an interpretation of UHC focuses on the mere element of affordability, or economic accessibility. It may pave the way to a massive infiltration of the private sector into healthcare systems that in some countries are still mostly public, and it may undermine the efforts of those countries that have undertaken reforms towards a stronger public sector.

To avoid this, UHC should aim at increasing the proportion of healthcare services that are mastered and managed by the public sector,[8] and financed by progressive taxation systems. In places where the private sector is prevalent and likely to remain so for a long time, governments should strongly regulate it, especially as far as quality of care and lucrative attraction for health professionals are concerned, while progressively investing to reinforce the public sector.[9] Also, UHC should be robust enough to accommodate new challenges, e.g., the new burden brought about by the changing epidemiology of non-communicable diseases,[10] and to resist the downward swings brought about by present and future economic and financial crises.[11] Ad hoc goals and targets on access to the public sector should be developed if UHC is included in the post-2015 development agenda.

3. Gluttony (over-consumption of anything to the point of waste) vs. Temperance (self-control, abstention, moderation)

Trade mechanisms will keep influencing the delicate balance between demand for and supply of healthcare services. Given the well-known asymmetry of information between providers and users in this atypical market, UHC should include mechanisms aimed at moderating any inappropriate excess of supply that in turn may end up increasing demand. Historically, this point has been raised by Ivan Illich: 'Although physicians did pioneer antisepsis, immunisation, and dietary supplements, they were also involved in the switch [from breastmilk] to the bottle.'[12]

Currently, demand may be artifi-

cially inflated by the push for new pharmaceutical or technological solutions to real or presumed health needs, in what is known as disease mongering.[13] Moreover, due to the liberalisation of global trade, the associated dissemination of unhealthy lifestyles, the aggressive marketing of healthcare products, the drive towards increasing consumption and waste, the legal obligations brought about by global trade treaties, and the lack of public regulations to protect public health, demand may rise above the capacity of healthcare systems to respond, creating imbalances that are difficult to address and that would be an obstacle to UHC itself.[14]

4. Pride (failure to acknowledge the good work of others) vs. Humility (thinking of oneself less in a spirit of self-examination)

UHC will positively affect health only if due attention is paid to its quality. Quality care is the delivery of safe and effective interventions in ways that, by taking into account the needs and the background of users and their communities, ensure the best possible outcomes to all. Quality of care has only recently been recognised as a neglected issue in the international health agenda, particularly as far as care around childbirth is concerned.[15, 16] Several studies and reports indicate that quality may be far from acceptable, thus jeopardising the ultimate aim of health services.

Delivering care which is not technically sound implies increasing the costs for the system and households without achieving health. Improving quality, however, implies no less difficulty than increasing access. A variety of approaches have been proposed, but reports of successful quality cycles are scant. Efforts to improve paediatric quality of care in district hospitals through systematic standard-based peer-review assessment have been successful, particularly when action at facility level is combined with action at national health system level, through introduction of national standards and improvement in all the building blocks of the health system.[17] The tool for paediatric care developed by WHO, and the equivalent maternal and neonatal assessment tool, are able to identify quality gaps and prompt quality cycles at local level and systemic action at national level.[18, 19] Market mechanisms alone, like those described by proponents of health insurance reforms,[20] are unlikely to have a sustained effect on quality of care.

5. Envy (desire to deprive other people of their abilities or rewards) vs. Kindness (empathy and trust without prejudice or resentment)

Health is a complex adaptive system within wider cultural, social and economic complex adaptive systems.[21] Changes in access to health brought about by UHC are likely to affect other building blocks within the health system, the training and distribution of the health workforce for example, or in other social sectors, the transport system for example.

Needless to say, the reverse is also true. A systems thinking approach is compulsory to try and predict the effects that modifications of the health system may have on other complex adaptive systems, and vice versa.[22] Parallel to UHC, capacity for a systems thinking approach should be built among policy and decision makers, as well as planners and researchers. This would be easier if UHC was integrated into a wider social protection framework.[23] To avoid increasing the gap between the better and the worse off, coverage and social protection should be preferentially provided to the latter group, at least initially.[24] This would be particularly important in places where financial risk protection and health insurance have proven to be difficult to implement and scale up, e.g., in remote contexts and poor, underserved communities.

6. Wrath (impatience, revenge and vigilantism) vs. Patience (creating a sense of peaceful stability rather than hostility and antagonism)

The implementation of UHC, with all its corollaries of principles, policies, activities and constraints, has to be properly governed and monitored. Governments will obviously be in charge of it at national and local levels. But who will be in charge of its governance at global level? WHO is the natural candidate, but in recent years it has failed to provide an effective and coherent leadership based on the principles of the right to health for all. Critical budgetary and organisational constraints, including donor dependence, contradictions in the management of human resources, excessive decentralisation and lack of accountability to member states weaken the role of WHO in global health governance. The current process of reform suffers from many of the very problems that it is meant to address, and may fail to re-qualify WHO for the governance of global health.[25]

However, there are possibly no alternatives to a strengthened normative role of WHO as advocated by Chen and Berlinguer over a decade ago.[26] With patience and courage, WHO could lead the development of new ad hoc regulatory frameworks, modelled on the Framework Convention on Tobacco Control. A strong alliance with civil society organisations that look after the public interest and identify global health as a common good would be an asset. While the authority of WHO and its treaty-making power remain necessary, the potential role of bottom-up strategies involving community participation should also be acknowledged. By encouraging social empowerment, increasing the potential to strengthen health systems at local levels, organising demand for services prioritised by communities, and linking generation of knowledge to its use in action, strategies such as participatory action research and community-based monitoring are increasingly recognised as key elements towards UHC.[27]

7. Lust (intense desire for money, fame or power) vs. Chastity (to be honest with oneself, one's family, one's friends and all of humanity)

Finally, UHC should be spelled out and positioned within a human

rights framework. The Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights clearly state that the fulfilment of the human right to health relies on the fulfilment of other rights, e.g., food, housing, work, education, non-discrimination, participation and freedom of association. More specifically, the International Covenant states that while 'the right to health is not to be understood as a right to be healthy', it is 'an inclusive right extending not only to timely and appropriate healthcare but also to the underlying determinants of health'. It adds that 'a further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels'.[28] It states also that 'The right to health [care] in all its forms and at all levels contains the following interrelated and essential elements': (a) availability, (b) accessibility in its four overlapping dimensions: non-discrimination and physical, economic (affordability) and information accessibility, (c) acceptability, and (d) quality of services. Unless the international community pushes the right to health up in its scale of values and stops considering health as a dependent variable of the global economy, and unless it makes the respect of human rights mandatory and those who violate them legally accountable, UHC is unlikely to yield the expected results.

To conclude, the incorporation of the UHC concept in the post-2015 development agenda should aim at maximising benefits and minimising harm. This can be achieved only if all the above criteria are met and built into UHC, with enforceable mechanisms to hold governments accountable. In particular, UHC should be understood as a way to ensure the right to health. Only within a human rights framework would UHC benefit from a comprehensive approach, as opposed to the fragmented, vertical approach entrenched in the health (insurance) coverage approach with multiple actors either on the payer or on the provider side that focus on personal, mostly disease-centred and curative services. Addressing UHC in a human rights framework will help re-position the right to health in the context of the post-2015 development agenda. ◆

Adriano Cattaneo, Giorgio Tamburlini, Angelo Stefanini, Eduardo Missoni, Gavino Maciocco, Gianni Tognoni, Carlo Resti, Claudio Beltramello, Chiara Bodini and Nicoletta Dentico are members of Italian Global Health Watch. This article is reproduced from the 'Get involved in global health' blog (getinvolvedinglobalhealth.blogspot.com).

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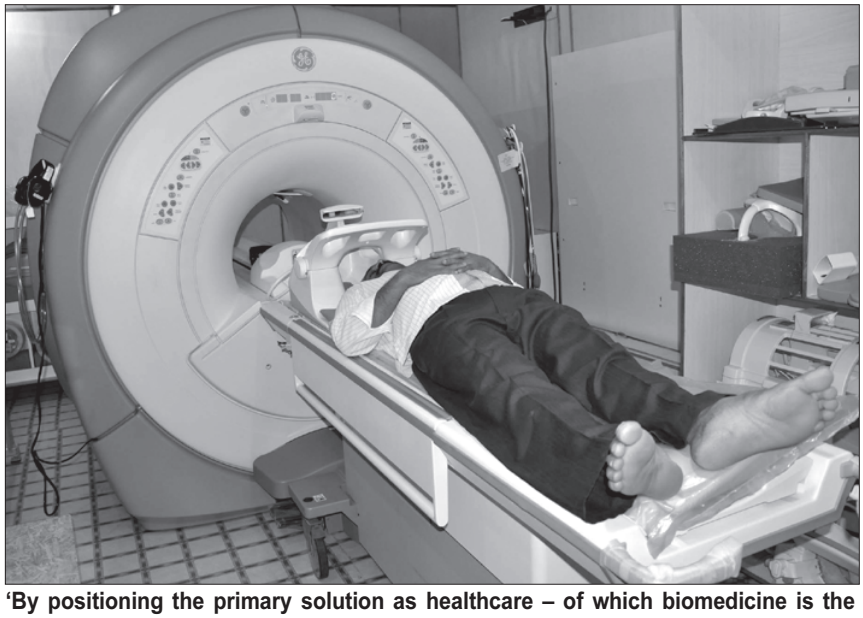
The universal health coverage campaign and the medicalisation of global health

By focusing almost exclusively on individual access to medical care as the solution, UHC ignores the social determinants of health and the need for political action to realise it, says *Jocalyn Clark*.

UNIVERSAL health coverage (UHC) – universal access to needed health services without financial hardship in paying for them[1] – has become the rallying cry for many in the global health community as the end of the Millennium Development Goals (MDG) programme approaches and a new agenda is being fashioned for 2015 and beyond. In the post-2015 'fervour',[2] UHC has emerged as the leading recommended overarching health goal, and has the support and endorsement of major institutions and organisations like the World Health Organisation (WHO), World Bank, the Foreign Policy and Global Health group, and the Rockefeller Foundation, among others, and a multitude of mostly supportive articles and editorials have been published in major medical journals, where UHC has been described by one leading journal as 'an insuppressible right'.[3] Concerned about rising and catastrophic healthcare costs, especially in low- and middle-income countries (LMICs), more than 90 countries in December 2012 endorsed a United Nations resolution on UHC,[4] which ensures its consideration in the broader development discussions. Others have projected that UHC – described as no less than a 'third global health transition'[5] and an 'epic transition'[6] – will not only improve access to healthcare but 'could have a transformative effect in the battle against poverty, hunger, and disease'.[7] While it is indeed still an 'aspirational slogan',[8] it is also difficult to argue with a concept that offers the promise of health services for everyone in the world who needs them.



'By positioning the primary solution as healthcare – of which biomedicine is the dominant, modern practice – the UHC campaign medicalises the agenda.'

But in the zeal to embrace 'the UHC mantra',[9] the conceptualisation and consequences of UHC – not as a normative good but as *the* singular priority in global health – have inspired relatively little critical examination. Among the few published critiques, some have raised concerns about the imprecision attached to calls for UHC where, for example, the range, quality and equity of services are inconsistently included and articulated in definitions,[8-11] and this imprecision is said to threaten consensus and appropriate policy responses.[8] Most reports and resolutions, in fact, fail to specify or make commitments to ensuring actual use, acceptability, quality or the necessity or appropriateness of health services, all of which are necessary for UHC to be effective.[8, 11] Others highlight the not inconsiderable challenges of implementing UHC at the country level, where the necessary financial, legal and policy ingredients to support an effective health system and requisite human resources are often missing or inadequate.[10, 12]

Insights from the tradition of medicalisation analyses, which have roots in sociology and social constructionist approaches, enrich these critiques and allow for an examination of the UHC campaign and its framing of this singular global health priority. A medicalisation lens can be useful for critically examining the contemporary global health agenda, including what and how issues and problems get prioritised and framed, and what solutions are advanced (see box on p.19). Unlike the cases of the medicalisation of global

health that I examine elsewhere – the global mental health movement[13] and the non-communicable diseases agenda[14] – where a health condition is promoted, defined and 'treated' in medicalised ways, here the interest is in how the UHC campaign positions access to healthcare as a core global health problem.

Viewed through a medicalisation lens, it appears that the UHC campaign is currently defined and framed in narrow terms, elevating the role of healthcare, individualising health by focusing on access to personal health services, and creating opportunities for commodification; together this reductionism risks medicalising a key and high-profile component of the current global health agenda.

I trace three features.

Action on the social determinants of health, such as environmental and living conditions, is essential to alleviate the gross inequalities in health that exist around the world.

Conflating healthcare with health

First, too often in the current UHC discourse there is conflation of healthcare with health, an important and misleading conversion. A recent call to action in *The Lancet*, for example, interchangeably uses health and healthcare, asserting that UHC addresses existing constraints to 'scaling up access to health' and that the hope is to ensure 'all of the world's people will have access to health at an affordable cost'.[7] Even the WHO Director-General's comments conflate health with healthcare services when declaring UHC, in 2012, to be 'the single most powerful concept that public health has to offer'.[15] In fact, public health's main contribution and worldview are to *deemphasise* the role of healthcare services and instead highlight the multiple influences that act on health, in particular, the social and political determinants.[16]

Positioning healthcare as equivalent to health in these development debates massively elevates the role of healthcare in alleviating global health problems that in reality are so centrally linked to poverty, power and inequity. In turn, by positioning the primary solution as healthcare – of which biomedicine is the dominant, modern practice – the UHC campaign medicalises the agenda. As has been argued in other medicalisation analyses where healthcare is offered as the solution to public health problems, the tendency is to focus strategies on increasing access to personal health services, often financial access. Policy responses then become about improving access to healthcare, displacing the more salient goal of improving health, and ignoring the socio-economic conditions that created the vulnerability in the first place.[17]

Similarly, when it comes to redressing disparities, a medicalised view conflates health status disparities with health access disparities, overvaluing and overemphasising healthcare access,[17] or, as Clift argues about UHC,[9] assigning 'undue importance to the delivery of healthcare services as a determinant of health outcomes and downgrading the importance of the [needed] economic, social, and environmental changes'.

As decades of reports and commitments by WHO and others have stressed, there are a multitude of factors affecting health, and healthcare is only one of them.[9, 18] Access to care is a necessary but not a sufficient determinant of health. Indeed, as O'Connell and colleagues point out, the definition of health present in the UN resolution on UHC is much broader than could be achieved through provision of basic or essential health services.[8] And although Marmot was referring specifically to primary healthcare in relation to UHC, his caution applies more widely: improvement of access to care 'is a worthy and necessary goal but, by itself, will not revolutionise global health, nor reduce large health inequalities'.[19]

This focus of the UHC campaign is of particular concern because the evidence suggests that healthcare on its own does not directly improve health outcomes. Historically, improvements in health and life expectancy were not the result of biomedicine but rather living standards, especially nutrition,[20] and more contemporarily, even with substantial modern medical and technological advances, estimates range from 10%[16, 21] to 43%[22] of health being a consequence of healthcare. Broader social and economic improvements are more likely to produce health gains, and furthermore healthcare can cause harm, be wasteful and be costly; Benatar stresses that the increasing medicalisation of health generates unsustainable costs for societies.[23]

In relation to the UHC agenda, in particular, Clift argues 'even if we achieve UHC as defined, … this

would not necessarily produce the best outcomes',[9] and Victora[18] warns that 'it is possible to have UHC while still having poor and declining population health'. Moreno-Serra and Smith, in a comprehensive review, show the mixed and patchy evidence base to support the contention that UHC leads to better population health outcomes, reporting that the relationship depends a great deal on the setting and its quality of governance and institutions, the characteristics of the system, the specific health indicators measured, methodological limits and the availability of data; they also highlight the importance of targeting care to those who need it.[24] While they conclude, optimistically, that policymakers should feel secure that steps towards universal coverage are an important strategy for population health, especially among poor people, this seems over-optimistic: it is clear that there is a scarce evidence base to support causal claims.[12] Indeed the 2013 World Health Report's central thesis is the strong need for more evidence on UHC.[25]

Reductionism in the UHC campaign

Second, the UHC goal risks medicalising health because it is reductionistic. Even in its broadest definition that might include preventative, rehabilitative and palliative care in addition to treatment, UHC clearly excludes the social and political determinants of health.[19] As the 1978 Alma Ata Declaration first committed to[26] and the 2008 Commission on Social Determinants of Health affirmed,[27] action on the social determinants of health is essential to alleviate the gross inequalities in health that exist around the world. In fact, several inputs to the post-2015 health and development agendas, including the Rio+20 declaration[28] and the inclusive World We Want consultation,[29] emphasise the need for health goals that address these broader determinants, including environmental and living conditions, nutrition, income, education, gender and race. Others broaden the frame[30, 31] to highlight the political determinants of health, arguing that the concentration of power in health agenda-setting, neoliberal ideologies and other dimensions of politics can have an enormous impact on the health and inequalities of societies, and as such the political context must be accounted for. In contrast, UHC, however essential, 'reflects preventive and curative actions delivered at [the] individual level'.[18]

In fact, positioning UHC with its individualistic approach as the preeminent health goal would appear to contradict previous global health commitments and resolutions that emphasise action on the social determinants of health and the need for political action and a long-term view. Without such a view, short-term thinking 'incentivises a focus on interventions, physical entities (vaccines, medicines, devices, equipment) that one can buy, distribute, and count the

Medicalisation lens

MEDICALISATION is a process by which human problems come to be defined and treated as medical problems. It involves the application of a biomedical model that sees health as freedom from disease, and is characterised by reductionism, individualism and a bias towards the technological. Medicalisation analyses have roots in social constructionism and sociology, revealing the ways that such varied conditions as addiction, childbirth, infant feeding, sadness, erectile dysfunction and death have come to be medical issues to be treated.

Medicalisation is understood to be expanding rather than contracting in modern life, and while it can be sought or resisted by patients, doctors or other actors in the health field, it is considered largely harmful and costly to individuals and societies: pathologising normal behaviour, disempowering individuals, decontextualising experience and depoliticising social problems. As Parens argues: 'Insofar as medicine focuses on changing individuals' bodies to reduce suffering, its increasing influence steals attention and resources away from changing the social structures and expectations that can produce such suffering in the first place.' (Parens E. On good and bad forms of medicalization. *Bioethics* 2013; 27: 28-35)

Medicalisation can play out at the level of interaction or of definition and agenda-setting, and analyses of medicalisation are particularly valuable at the definitional level. A medicalisation lens can be useful for critically examining the contemporary global health agenda, exploring how and why certain issues elevate to prominence and raising questions such as:

- How is the issue framed as a problem in global health and what solutions are presented?
- To what extent and how are priority issues defined as diseases, strategies for treatment and other healthcare technologies recommended, and individual versus social solutions advanced?
- What is the role of medical providers or of a biomedical model conceived to be or promoted?
- How do advocacy groups, civil society and/or industry reinforce, benefit or challenge the medicalisation of the global health issue?
- Who benefits from the framing of the issue and its solutions, and what is discounted?

A medicalisation lens helps uncover areas where the global health agenda and its framing of problems are shifted towards medical and technical solutions, neglecting necessary social, community or political action.
– *Jocalyn Clark*

effects of quickly'.[32]

UHC has been described as a 'silver bullet solution' to healthcare needs in LMICs[12] and, when focused on expanding networks of healthcare professionals and institutions, can produce a medicalised vision of health that simply makes more medical treatments available to more people.[23] Like other target and priority settings in global health, silver- or magic-bullet solutions are often favoured because they are seen as being easier to monitor, implement and measure; able to produce immediate results and quick wins; and aligned with the existing agendas of national or international institutions.[33, 34] But emphasis on the individual level deflects attention from the political context and from population-level interventions such as taxation of harmful products; legislation of nutritional content of foods; and policy reforms to promote physical activity, fund preschool education, improve housing quality or ensure water and sanitation infrastructure, among others, that can improve communities' health.[18, 19]

Ignoring the social and political context means that the UHC goal can overlook the action needed outside the health sector, including the economic and social sectors enshrined in Alma Ata as of 'basic importance to the fullest attainment of health for all'.[26] While some proponents claim that UHC is rooted in the human right to health,[35] others argue it ignores international agreements on health and human rights:[11, 36] Ooms and colleagues assert that UHC on its own is not enough to ensure the right to health without policy commitments to also ensure underlying determinants of health, and more robust civil society participation and collaboration with the communities whose health is at stake.[2]

Financing eclipses service delivery

The third issue fuelling the medicalisation of health is the priority given in the UHC campaign to financing rather than service delivery. Such framing – where the promise is said to lie in pooled financing not pooled provision[12] – and in particular its lack of explicit support for public health systems strengthening, provides wide opportunities for profit-making and risks commodifying healthcare.

As Sengupta argues,[12] the predominant definition of UHC is 'a health financing system based on pooling of funds to provide health coverage for a country's entire population, often in the form of a "basic package" of services made available through health insurance and provided by a growing private sector'. Most reports fail to emphasise the importance of public health services, instead focusing on cost-effectiveness and efficiency,[12] which are values of medicalisation.[37]

In the leading model of UHC, the state's role is to manage, regulate and possibly purchase services, but the health services themselves are conceived as marketable commodities and they create an entry path for private insurance companies, private healthcare providers and managed care organisations.[12] Thus, UHC can contribute to new and broader healthcare enterprises by transforming the healthcare needs of a population into specific commodities, defined by (mostly medical) experts, for economic markets.[38] As with the growing commodification of aging,[38] this is a form of medicalisation. Such a model ignores the implications for equity, whereby private systems may avoid providing care to the poor, aged, chronically ill or other patients who have conditions requiring costly or long-term care. In turn, this risks diverting attention and investment away from strengthening or rebuilding public health systems to provide UHC. Or, as Sengupta argues, this represents a 'private sellout of health systems via UHC'.[12]

The focus in the current UHC campaign and this framing also represents a turn away from Alma Ata commitments and the thrust of most campaigns for health systems strengthening that seek integrated, equitable and community-driven systems. Freedman and colleagues have proposed a conceptualisation of the health system as a core social institution that functions at the interface between individuals and wider structures of power,[39, 40] which is thus capable of setting and reinforcing social norms. A context in which healthcare is bought and sold like a traded commodity risks the social legitimisation of the exclusion of those without the ability to pay. Indeed, even strong proponents of UHC suggest there is no guarantee that it can ensure that healthcare remains a collective good,[7] and critics call instead for a strengthening of the underfinanced public sector.[12, 41]

How can the UHC campaign avoid medicalisation?

There appear to be several ways that the UHC campaign can broaden the discourse to avoid contributing to or fuelling the medicalisation of global health. First, it would seem essential to cease confounding health and healthcare, which is misleading and inaccurate. Irrespective of one's view of the relative contribution of health services or the health system to health, it is wrong to conflate in debates on UHC the terms 'healthcare' (or 'health services') with 'health'. This serves to erroneously promote the idea that health is achieved by healthcare alone, and elevates the position and role of biomedicine in solutions, policy responses and investment, distorting the broader determinants of health and threatening the success of proposed interventions.

Prioritising a goal that emphasises the importance of access to healthcare takes attention away from the social and political determinants of health, which, as a second recommendation, clearly must be better incorporated into the UHC campaign and goals. To galvanise support for this broadened campaign and goal, Marmot says, the global health community can take action on the social determinants through 'changes in clinical practice, partnership working, advocacy, education and training, and employment conditions of health-sector workers'.[19] Health workers can

also lobby for a much-broadened goal that avoids medicalisation, perhaps along the lines of a recent Go4Health report that advocates for a broad goal of realising the right to health for everyone, supported by two secondary goals of UHC anchored in the right to health and in healthy social and physical environments.[42] Further, Navarro and others argue that no consideration of the determinants of health is complete without examining the politics and power relations of the system in which priorities emerge,[30, 34] and thus more attention to how the global political economy enables or obstructs achievement of UHC is needed.

Third, equity would seem a particularly important dimension to tackle further within UHC efforts as it appears to invoke a difference of opinion.[25, 31, 43, 44] Whilst the early positioning of UHC would suggest that universalism and removing financial hardship equate with equity, some commentators argue that simply providing coverage of the status quo (more of the same) will reproduce present inequities.[8, 31] Furthermore, health inequities can increase when, for example, only wage earners or those working in formal sectors access available health services, excluding the poor.[43] In O'Connell and colleagues' analysis,[8] the assumption that equity is a natural consequence of UHC contrasts with the evidence showing that improved equity is 'conditional on how UHC terms and policies are defined, designed, implemented, and sequenced'.

Consequently, an explicit equity focus will need 'hard-wired' measurement and independent accountability, which has been highlighted in critical analyses of the MDG targets and implementation;[31, 33] otherwise, the UHC campaigns risks worsening inequities. As Waage and colleagues[33] argue more generally but relevantly for extending coverage of universal healthcare, 'issues of equity arise because many goals target attainment of a specific minimum standard … [but] to bring people above this threshold might mean a focus on those for whom least effort is required, neglecting groups that, for geographical, ethnic, or other reasons, are more difficult to reach, thereby increasing inequity'.

Fourth, debates about the value and implementation of UHC must further incorporate discussions and analyses of the political dimensions (as mentioned earlier), and must specify the roles and appropriate contributions of both the public and private sectors, recognising the power of vested interests. The normative analytical frameworks of global health research (biostatistics, epidemiology, health economics) concern themselves with more proximate indicators of health, excluding due attention to the root causes and to the politics in public health, a scenario that Navarro describes as disinclining researchers to tackle the 'dirty issues' that may disrupt the neutral agendas of public funders.[30, 45] But more analysis of the political dimensions and the global political economy is very much needed, and would widen the discourse beyond its current framing as a largely technical and financing issue; indeed, as Stuckler and colleagues have argued, adopting UHC and how it is implemented are primarily political choices.[10]

Since medicalising health props up an apolitical position with regard to UHC, it stands to reason that challenging medicalisation could be served by introducing the importance of political processes to the realisation of UHC. This then requires political debates and commitments to equity, quality and collective responsibility that could fulfil the expectations of UHC to provide a significant global health transition and 'transform poverty, hunger, and disease'. Furthermore, determining what individuals or communities want from healthcare coverage is not a technical issue either, but one of social value.[8] Finally, more evidence is clearly needed on the outcomes and implications of UHC in practice, particularly in regard to health goals that aim for equitable and quality care. ◆

Jocalyn Clark is executive editor and scientific writing specialist at icddr,b (a global health research organisation in Dhaka, Bangladesh). She is also Adjunct Assistant Professor of Medicine at the University of Toronto in Canada. *This article is reproduced from* Global Health Action *(Vol. 7, 2014, www.globalhealthaction.net/index.php/gha/article/view/24004) under a Creative Commons licence.*

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The trap underlying 'universal health coverage': The struggle to realise the right to health in Latin America

Drawing on the experience of Latin America, *Rafael Gonzalez Guzman* and *Nashielly Cortes Hernandez* warn that behind the proposal of UHC lies a hidden agenda related to the commodification of healthcare through the participation of insurance companies and large private healthcare providers who profit from public funds allocated for health.

'UNIVERSAL health coverage' (UHC) is a concept that is being widely deliberated upon across the globe. Prominent in popularising the concept have been the Rockefeller Foundation, the World Bank, the US Agency for International Development (USAID) and even the World Health Organisation (WHO). The concept is generally presented as a cube with three axes representing the number of people covered by health systems; the number of medical interventions provided; and the amount of money necessary for financial protection that would cover for catastrophic expenses on healthcare incurred by poor families. However, behind this proposal for UHC lies a hidden agenda related to the commodification of healthcare through the participation of insurance and large private healthcare providers who seek to extract profits from public funds allocated for health. Typically, in many settings, UHC provides insurance coverage to the poor[1] for a limited package of services.

Colombia was one of the first countries in Latin America to introduce universal health coverage.

The terms 'universal' and 'coverage' appear to denote comprehensiveness and fairness, but their concrete application in some countries of Latin America is indicative of a clear trend. It is typified by the participation of insurance companies (the term 'coverage' is insurance language), which open up public funds for health to for-profit healthcare providers. While, to start with, local private providers are involved, they can rapidly be replaced by transnational companies. Some of these are now entering several Latin American countries that pursue neoliberal policies (Colombia, Chile, the Dominican Republic and Peru). The progressive and intentional weakening of public services and the entry of private service providers is promoted on the grounds that private sector participation improves the quality of services provided. However, there is no systematic evidence supporting the contention that private providers are more efficient.[2]

UHC promotes inequity in healthcare because there is a wide variation in insurance coverage available to different sets of the population. Inequity is embedded in the system: private plans for the rich have wider benefits; plans for formal sector workers have wide benefits but they face overcrowding and long waiting times; and informal sector or rural workers are covered by a very limited package of services. The reality is even worse, because this new structure also leaves out significant sections of the population. Therefore UHC acts against the fundamental right of every person to have secure access to healthcare.

Experience with UHC in some countries in Latin America

In the Dominican Republic, two major super-specialty hospitals were transferred to private providers. This model was subsequently extended to other 'self-managed' hospitals and primary care centres, which receive from the state per capita payments for each person insured. The state funds are managed by Health Risk Administrators (ARS) – private companies which stand to profit through a reduction in benefits available to those who are insured. In addition, those insured are also required to make co-payments for certain conditions, or pay the entire cost if a procedure is not included in the insurance package. Contrary to the popular discourse that UHC results in reduction of out-of-pocket expenses on healthcare, such expenses incurred by families increased by 60% between 2007 and 2012. A new form of segmentation of the health system is emerging, based on the ability to pay, even while on paper universal coverage has been achieved! At the same time the ARS are making huge profits, valued at a return of almost 20% on investment per annum.[3]

Colombia was one of the first countries in Latin America to introduce UHC. In the process the public system was dismantled and health insurance companies (EPS) emerged as key players in the health system. These companies have two distinct schemes, one for formal workers and another for informal workers, peasants or others who have documents to prove that they lie below the poverty line. The latter scheme has a limited package of benefits and patients must pay if the services required are not included in the package.

Both insurance companies and healthcare providers seek to increase their profits by reducing the range of services provided, even in cases where services are included in a package. This has led to a very large number of complaints called *tutelas* (*tutelas* relate to a provision in the Colombian constitution that allows citizens to file complaints when their right to health is not upheld) being filed against insurance companies. Most of these complaints pertain to deficiency in providing services included in the benefit package announced by insurance companies. Adding to the public sentiment against the insurance companies has been several reports in the Colombian press regarding the large profits enjoyed by these companies and the very high salaries drawn by the company directors.

In the Mexican healthcare system, insurance companies manage the funds allocated to the universal scheme that offers a very limited package of services.

Yet, in 2014, the Colombian government approved a change in the law that limited the financial resources that can be used for health. It also approved a new provision that would override the use of *tutelas* to seek remedy against deficiencies in the services provided by insurance companies. The Colombian Constitutional Court modified the proposal by the government and replaced the limited packages of services provided by insurance companies with a 'negative list' of benefits that would be excluded from the insurance package.[4] This is likely to have the same effect, as earlier, of limiting coverage.

Peru is presently engaged in a process to reform its health system with active support from USAID. Peru offers a very limited insurance package that covers the poorest, who do not have social security protection as part of their conditions of employment. It is a very limited package that reproduces inequity in healthcare. One part of the reforms initiated by the government facilitates the entry of private finance through their agents, who would be allowed to operate public funds in health as profit-making ventures. Although the reform is being promoted under the slogan of financial protection, out-of-pocket expenditure on health has increased from $3.4 billion in 2009 to $4.35 billion in 2013.[5]

The government of Mexico has attempted to follow the example of Colombia over the past decades. The first phase of reforms, involving structural adjustment policies, led to a weakened public system and an increase in fees for services for people without social security, thereby reducing access of the poorest people to healthcare services. In the next phase, instead of lowering fees, an insurance package with limited services called popular insurance (*seguro popular* or SP) was introduced to address the healthcare needs of those not covered by social security. For example, patients with myocardial infarction would be covered by the package only if they are under 60 years old. Also excluded from the package is dialysis, frequently needed for patients with chronic diabetes (diabetes is the leading cause of death in Mexico). Services not included in the package need to be paid for to the service pro-

vider and the fees for such services are often very high. Like in Peru, out-of pocket payments are very high – for each peso spent out of pocket by the people insured through SP, the insurance companies spend only 0.93 pesos.[6]

In the Mexican system at present, insurance companies manage the funds allocated to the universal scheme (SP) that offers a very limited package of services. It has the effect of limiting access to a much smaller package of benefits as compared to what was traditionally available through social security. At the same time the system facilitates the entry of private providers, which are linked to the insurance scheme.

A recent World Bank study, which evaluated the insurance-based model of UHC, concluded that UHC-based reforms had not improved the health conditions of concerned populations. This is because the reforms implicit in UHC relate only to financial protection and promote a market for healthcare services that is exploited by insurance companies and private providers. The insurance-based model of UHC also has the effect of pushing up public health budgets.[7] These reforms also create new forms of inequity as a consequence of different insurance packages that differentially service the needs of the rich and the poor.

Another effect observed in Colombia, Peru and Mexico is the deterioration of the conditions of work of health workers.[8] For example, in Mexico, health workers in SP earn between 50% and 60% less than what workers earned before the reforms,[9] and the conditions of work for physicians, nurses and other health workers in the private sector are worse than for those in public services.

The alternative experience

Several countries in the Latin American region which pursued neoliberal policies saw an increase in poverty and a widening of the gap between a handful of rich and millions of working people. Social mobilisation overthrew many neoliberal governments, leading to the emergence of so-called progressive governments (such as in Venezuela, Bolivia, Ecuador, Brazil, El Salvador, Uruguay and Argentina). Instead of implementing neoliberal policies, these governments are promoting policies that support the right to health and the de-commodification of healthcare.[10]

In these countries the core principle being followed is that equal needs in health must receive the same attention, independent of the ability to pay. The best way to pursue this principle lies in the construction of a public, single, free-of-charge and accessible health system. In most parts of Latin America, before the advent of neoliberal reforms, public health systems were built that were a mix of the Beveridge and Bismarck models prevalent in Europe. The construction of the public systems was often achieved as a result of a range of popular struggles in the 20th century. In contrast to neoliberal regimes, progressive governments in Latin America are engaged in the strengthening and unification of public institutions with a view to creating a single system that provides universal access to the entire population. Instead of a mix of public and private funding and co-payments by patients, the system is sought to be financed by a progressive taxation system and employer contributions as part of social security. The proportions of the two vary depending on the specific characteristics of each country.

This model has been called an impossible utopia, but has existed for decades in Cuba – a country with some of the best health indicators in the entire continent. Such a system still exists in many countries of Europe and also in Canada. The current Latin American perspective towards building inclusive public systems differs from that in Europe with the addition of a very important component: popular participation in the construction and conduct of the system. The idea promoted is that the right to health cannot be achieved through market mechanisms and requires the active involvement of popular and citizens' organisations.

The construction of such a system (which is public, single and universal) is not easy. Important challenges include: the long history of scarce allocation of resources for public systems; the inequality in funds between different public institutions obstructing their unification in the short term; opposition by medical elites and a section of politicians and the bureaucracy; inadequate human resources and the opposition from some universities to developing appropriate curricula; the presence of a large private sector; and also the trend in some sectors (like white-collar workers) to demand private provision and expensive insurance coverage. Progressive governments require support in order to navigate these challenges and make innovative advances.

Venezuela is an example of this trend. As part of the country's Bolivarian Revolution, the Hugo Chavez government decreed that any person could access social security services, services provided by the health ministry and those provided by the armed forces. But even with this, millions of poor people did not have secure access to healthcare facilities. Workers in many sectors had private insurance plans paid by public or private employers (almost 500 different insurance plans). The Constituent Assembly established the creation of one universal, single, public and free health system.[11] But the advance towards this system has not been easy.

The first and most important step in this direction was the nationwide application of the experience of solidarity born in the slums of Caracas through the Barrio Adentro Mission.[12] Across the country a network of healthcare facilities, supported by Cuban general practitioners, was established in the first phase. In 2013 this network had 13,713 primary care centres that provided almost 500 million consultations a year. In the second phase integrated healthcare centres (CDI) were built that provide emergency care services and a range of diagnostic support. In 2012 the Barrio Adentro Mission had 1,939 CDIs. Beside each CDI was constructed a rehabilitation unit for the

care of disabled people. Currently the third phase is beginning with construction of new hospitals, including specialty hospitals (for example, for paediatric surgery), and an increase in the number of public hospital beds.[13] In Barrio Adentro all services are free and accessible to everyone. Unlike in the case of limited insurance plans, all users receive equal treatment. Alongside this the popular participation of local communities is contributing to the building of bottom-up structures of governance of the health system.

Meanwhile the Venezuelan government has built a new university (the Bolivarian University) which is engaged in training thousands of new doctors who will replace the Cuban doctors. Currently more than 17,000 integrated community physicians have graduated, and many of them are pursuing postgraduate studies in family medicine. The advances in building a public system for healthcare run parallel to several other social programmes to reduce poverty and inequity in Venezuela, such as programmes aimed at reducing the number of informal jobs, decreasing significantly the incidence of malnutrition, and building thousands of new houses for the poor.

Another important experience is ongoing in El Salvador. The progressive government of Mauricio Funes and now of Salvador Sanchez Ceren inherited a public health system that had been dismantled and privatised in several areas by the previous, neoliberal government. With the support of popular mobilisation the government initiated a process to reform the system. Fees for healthcare services were abolished, thus making all services free for the entire population. This simple measure increased access to healthcare by 30-40%. The health budget was increased for all levels of the system. Networks of community health centres were built in regions that had poor services to start with. Public hospitals, dismantled by the previous regime, were rebuilt and the number of hospital beds increased significantly. The new government introduced a new drug law that checked the activities of multinational drug companies and increased access to drugs.[14,15] The reforms in El Salvador weren't just driven by professional and technical experts. The National Health Forum, a broad-based popular organisation that is independent[16] of the government, also played a key role in shaping the reforms.

Under the Barrio Adentro Mission programme in Venezuela, healthcare services are free and accessible to everyone.

In only six years since the initiation of the reforms, positive results are visible in the form of an improvement in the health situation and a reduction of inequity in access to healthcare. El Salvador, classified as one of the poorest in the region, is one of the few countries in Latin America to have achieved the Millennium Development Goal target for maternal mortality. As in Venezuela, health reforms in El Salvador are being pursued hand in hand with social policies that improve the conditions of living and reduce social inequalities.

Brazil, the biggest country in Latin America with a population of 190 million, is another country that has made significant progress towards development of a unified public health system. A 'Single Health System' (SUS) was created as a product of a broad-based social mobilisation which fused together, in 1988, the struggle for democracy and the struggle for the right to health. Students, public health professionals, peasants, ecclesiastical communities, trade unions and political leaders participated in this mobilisation. This process culminated in a constitutional change, through which emerged SUS: a single public, universal, free-of-charge system that unified the social-security-based health system and the services of the Health Ministry (traditionally separated in almost all Latin American countries). This system is accessible to all Brazilians and provides free access to even complex interventions (for example, every year SUS provides facilities for 24,000 organ transplant operations, 84,000 cardiac surgeries and 62,000 oncologic surgeries).

While SUS was initiated after the overthrow of the dictatorship in 1988, it was initially starved of funds by the neoliberal governments that followed. This led to the development of a huge private medical sector which still accounts for about half of the country's healthcare costs. Since the last decade progressive governments, led by Lula and Dilma Rousseff, have been engaged in strengthening SUS. As a result, currently, SUS addresses the healthcare needs of about 160 million people and recent efforts target distant rural communities without medical facilities. However, the private sector continues to be powerful in Brazil and many people working in different sectors (including government employees) are covered by private insurance plans. While SUS provides support for expensive procedures not covered by private insurance plans, there still exist gaps in its ability to provide the entire range of services.[17] Thus SUS is still depend-

ent on private providers for the provision of some hospital-based services (such services are purchased by SUS from private providers). At present, the challenge in Brazil is to further strengthen the capacity of SUS so as to avoid the existing, though limited, dependence on the private sector for provision of hospital-based care services.[18]

Conclusion

The cases addressed above show two different trends regarding the progressive realisation of the right to health. The first trend is an attempt to reconcile the health needs of the population with the interests of insurance companies and private providers of healthcare. In countries which follow this logic, inequity is reproduced in new forms and public funds are utilised to support the profits of the private sector. The second trend is based upon the construction of public, single, free systems with popular participation. The logic underlying this system is that health is not a commodity but a right. Such a system does not include limited packages; the expansion and unification of a single system, providing services according to need, is the main task to be achieved. Barriers to the development of such a system can only be overcome through strong popular participation in its construction. ◆

Rafael Gonzalez Guzman is a Professor in the Faculty of Medicine at Universidad Nacional Autonoma de Mexico and Executive Secretary of the Latin American Social Medicine Association (ALAMES). Nashielly Cortes Hernandez is a Professor in the Faculty of Medicine at Universidad Nacional Autonoma de Mexico and is also with ALAMES.

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China: A question of equity

While the economic reforms instituted to transition China from a planned economy to a market economy have produced extraordinary economic growth, they have also resulted in public access to healthcare becoming more inequitable. The Chinese authorities are very concerned about this problem and are grappling with it.

Heather Mullins-Owens

Market-led reforms in China have made public access to health services more inequitable.

IN the past few decades, China's economy has transitioned steadily from a planned economy into a market economy. This shift has created many changes in the availability and access to health services for poor and middle-class citizens. Although overall, the country has gained tremendous wealth under the market economy system, the inequity of wealth has never been greater. Reforms in public and government institutions in China have made public access to health services for populations more inequitable (Gao, Tang, Tolhurst & Rao, 2001).

From 1950 to 1980, China had 'a healthcare system that provided almost all its citizens with access to basic health services at an affordable price' (Gao et al., 2001, p. 302). Two primary healthcare services entities provided coverage to many people in urban areas, the Governmental Insurance Scheme (GIS) and Labour Insurance Scheme (LIS; Gao et al., 2001). The GIS covered government and public sector workers as well as university students (Gao et al., 2001). The LIS provided coverage for state-owned and collectively owned enterprise workers (Gao et al., 2001). Although these plans originally provided full coverage at no cost to the employees and students, changes were later made to some plans to control costs, introducing co-payments such as those familiar to American workers with employer-based insurance plans (Gao et al., 2001). Adding to the inequity issue in urban China are the increasing numbers of migrant workers in urban areas, increases in unit costs for healthcare and drugs, and larger numbers of people working for small private or collectively owned firms (Liu, Hsiao & Eggleston, 1999).

According to Yuanli Liu (2004), from 1949 to the early 1980s, 'China's health policies emphasised prevention and public health, wide entitlement and access to medical care, and the use of minimally trained health personnel ("barefoot doctors") to provide basic health services ... [which helped lower infant mortality] from about 250 per 1,000 live births in 1952 to 34 per 1,000 in 1985 and increase life expectancy from about 35 years to 68 years during the same period. However, improvements in health stagnated during the period of economic reforms, and inequalities in health and access to healthcare have increased.' (p. 533)

During the mid-1980s, commercialisation of the health sector began as the government tightened public hospital budgets and reduced funding for other health service organisations (Liu, 2004). Providers were expected to generate enough in revenues to cover the difference between the public funding and their costs (Liu, 2004). Providers were also permitted to mark up the price of drugs by 20%, giving incentives to providers to prescribe more frequently than may be medically necessary (Liu, 2004). Not only did this further increase disparity in care among different income groups, it also shifted the nation's health services system from a more historically preventive system to one focused on 'revenue-generating activities' (Liu, 2004).

Rural health services

China's historical rural healthcare system had been a three-tier system, utilising a village health station, township health centre and county hospital (Liu, 2004). This system had used a referral process for patients, which began with the 'barefoot doctors' who treated the simplest illnesses and diseases, and referred patients to the upper-tier facilities for those things they could not adequately treat themselves (Liu, 2004). Under the Cooperative Medical System, health services financing came from a pre-payment plan through which farmers paid 0.5% to 2% of the family's annual income,

a village Collective Welfare Fund, and governmental subsidies (Liu et al., 1999). Ninety percent of rural citizens were included in one of these plans in the late 1970s (Liu et al., 1999). By the early 1990s, less than 10% had access to healthcare insurance (Tang & Bloom, 2000).

During the economic reforms of the previous two decades, the rural Cooperative Medical System became increasingly fragmented as various facilities began competing for patient-generated revenues, with some of the entities becoming privatised (Liu, 2004). As the Third Plenary of the Tenth Congress of the Communist Party 'ratified a programme of economic reform aimed at implementing China's transition to a market economy with socialist characteristics' (Mechanic, 1978, p. 190), changes began which sought to decentralise the rural health system (Tang & Bloom, 2000). As Tang and Bloom (2000) explain, the economic restructuring of the early 1980s played a large role in what has become a rift in health services equity (and overall economic equity) between rural and urban Chinese:

'[In 1983-84] … the rural economy was de-collectivised and all townships and villages adopted the "household responsibility system", which entitled each household to work an amount of land in proportion to its size. Households now have full financial responsibility for production. This has reduced the capacity of local administrative bodies to mobilise resources for collective use. In the meantime, local governments and state enterprises have been given greater autonomy. An important aspect of financial reform was a re-arrangement of revenue sharing between the central and local governments. This has allowed particular regions and sectors to race ahead, whilst some poorer regions have experienced major financial difficulties.' (p. 191)

Health service management centres now receive their funding from their township government rather than from the county (Tang & Bloom, 2000). This has greatly reduced the level of funding, as well as likely increased corruption and poor management practices driven by other (non-health) interests. Tang and Bloom (2000) cite an example: '[A] Deputy Director of one health centre reported that the township government asked local public institutions to assign their staff to working groups put together to undertake tasks, such as purchasing grain during the harvest season and forest protection. The government threatened to hold back its grant if the health centre refused to provide staff for these activities. He had to comply, to the detriment of service provision.' (p. 191)

China's historical rural healthcare system relied on minimally trained health personnel called 'barefoot doctors' to provide basic health services.

The Ministry of Health attempted to prevent the number of dedicated healthcare workers in the health centres from falling too low by passing regulations requiring that no more than 25% of health centre employees be non-medical employees; however, by the mid-1990s, it was clear that even these guidelines were not being enforced in rural areas (Tang & Bloom, 2000).

Healthcare after the economic restructuring of the 1980s

Although urban populations overall fared better financially during the 1980s economic restructuring, they are not without major problems in equitable access to health services. Between 1993 and 1998, data collected from more than 16,000 households in a survey study showed the changes in access to health services among different income groups in urban China (Gao et al., 2001). During these years, the income gap increased, while there was a decline in the population covered by the LIS and GIS (Gao et al., 2001). The number of people during this time frame who paid out of pocket for health services increased from 28% to 44% (Gao et al., 2001).

One of the most telling facts obtained from this study was that use of outpatient services decreased from 4.5% in 1993 to 3.0% in 1998 (Gao et al., 2001). During these years, the proportion of people covered by the GIS and LIS declined from 52% to only 39%, and those without any insurance rose from 28% to 44% (Gao et al., 2001). Those 'less likely to be able to cover the costs of healthcare were also less likely to have health insurance' by 1998 (Gao et al., 2001, p. 306). The gender gap also appeared to widen, with only 41.9% of women with insurance in 1998 compared with 46.3% of men (Gao et al., 2001). The primary reason cited for not seeking outpatient services among those who had an illness that went untreated was

financial difficulty (70% in 1998 vs. only 38% in 1993; Gao et al., 2001).

Inpatient hospital services are typically the most expensive services and may also provide a strong indicator as to economic barriers to care (as patients are less likely to be admitted if they do not have insurance or means of out-of-pocket payment; Gao et al., 2001). Surveys show a strong drop from 1992 to 1997 from 4.5 inpatients per 100 people to 3.0 inpatients per 100 people (Gao et al., 2001). In 1992, 68% of those in the lowest economic group needing inpatient services but not utilising them cited financial difficulty as the reason; in 1997, that percentage grew to 86 (Gao et al., 2001). Perhaps more interestingly, this difficulty in affording hospital care grew dramatically among the highest income group as well, from only 7% in 1992 to 31% in 1997 (Gao et al., 2001). Gender-based difficulty expressed itself with 55.6% of men and 64.8% of women attributing lack of services used due to finances (Gao et al., 2001).

Gao et al. (2001) have concluded from the data analysis that 'access of the urban population, particularly the poor, to formal health services has worsened and become more inequitable since the early 1990s. Among possible reasons for this trend are the rapid rise of per capita expenditure on health services and the decline in insurance coverage.' (p. 302)

This has been attributed in part to the rapid growth in health expenditures and lack of adequate mechanisms with which to control 'service providers' behaviour, heavy provider reliance on fee-for-service payment methods, and price distortions in the health sector' (Gao et al., 2001, p. 309). Health providers are permitted to 'make profits from drug sales and the provision of sophisticated diagnostic tests, while they keep prices of basic services at a lower level than real costs' (Gao et al., 2001, p. 309). As such, over-prescribing of prescriptions and misallocation of resources towards inflated uses of expensive drugs and technologies are driving economic inefficiency in China's healthcare system (Gao et al., 2001).

The increasing migrant labour force in China's urban areas may add to public health concerns as they often suffer from poor health conditions, low wages and reduced access to care.

The Chinese government has continued to exhibit a weakened role in terms of ensuring citizens have access to healthcare. China's national spending on health services as a percentage of GDP rose from 4.11 in 1991 to 4.82 in 2000 (Liu, 2004). However, government spending on healthcare as a share of total health spending diminished from 22% in 1991 to just 14% in 2000, while costs for care increased substantially (Liu, 2004). Out-of-pocket spending skyrocketed from 38% in 1991 to 60% in 2000 (Liu, 2004). Governmental spending on public health efforts also decreased 5% overall during the same nine years (Liu, 2004). Experts in the field of public health agree that China's continuing environmental pollution, lack of clean water supply, and easing of internal travel restrictions, in addition to more international travel threats and potential epidemics such as severe acute respiratory syndrome (SARS), should have called for increased spending during these years (Liu, 2004). The increasing migrant labour force in China's urban areas may add to the concerns of future epidemic outbreaks as they often suffer from poor health conditions, low wages and reduced access to care (Liu et al., 1999). These factors are worsened by the fact that this population is highly mobile, and epidemics may be faster-spreading and harder to trace.

What has been done about the lack of access to care?

The Basic Health Insurance Scheme (BHIS) was launched to fill the void of the existing GIS and LIS systems (Ramesh & Wu, 2009). Unfortunately, BHIS was offered only to urban employees and was not available for informal sector workers or migrant workers (Ramesh & Wu, 2009). Dependents were also left uncovered by BHIS. BHIS was funded by employees at a rate of 2% of their salary and by employers at 6% (Ramesh & Wu, 2009). Only 28% of all urban populations were covered by BHIS as of 2008 (Ramesh & Wu, 2009).

In 2002, an attempt was made to improve rural care as well (Ramesh & Wu, 2009). The New Cooperative Medical System (NCMS) was offered at HK$1.25/year with the government spending an additional HK$2.50/year in subsidies (Ramesh & Wu, 2009). The government subsidy was increased to HK$6/year by 2007, amid concerns of financial vulnerability, which increased voluntary enrolment in the plan to more than 80% (Ramesh & Wu, 2009). In 2010, the fee increased to HK$4.50/month for partici-

pants, with local and central governments contributing HK$18.00/month (Ma, Zhang & Chen, 2012).

NCMS offers three schemes, chosen by the local government. The first funds hospitalisation expenses and some expenses for the treatment of serious illness. The second scheme funds hospitalisation and some outpatient costs not restricted to serious illness. The third and most comprehensive scheme covers hospitalisation costs and provides health savings accounts for other medical expenses. Although the third scheme offering comprehensive coverage is very popular in the regions in which it is offered, the programme would not be sustainable if offered in all regions (Ma et al., 2012). Unfortunately, offering the least expensive option, Scheme 1, results in the lowest levels of participation in poor rural areas (Ma et al., 2012).

The Urban Resident Basic Medical Insurance (URBMI) was initiated in 2007, modelled after the State Council Policy Document 2007 No. 20's guidelines (Lin, Liu & Chen, 2009). URBMI appears to benefit the lowest-income participants the most, along with those receiving inpatient care (Lin et al., 2009). Enrolment in URBMI is a voluntary decision made by each household, and coverage focuses on chronic and fatal conditions (Lin et al., 2009). Premiums are set at higher rates than similar NCMS (Lin et al., 2009) schemes. On average, URBMI covers 45% of inpatient costs (Lin et al., 2009).

Is insurance the answer?

Perhaps the most troubling aspect of the various attempts to provide medical insurance coverage in China is that insurance coverage may be resulting in higher out-of-pocket costs for the insured than they would have experienced if they were uninsured (Wagstaff & Lindelow, 2008). According to Wagstaff and Lindelow (2008), results from 'three separate household surveys suggest that in China health insurance is more likely than not to increase out-of-pocket spending and to increase the risk of catastrophic and large expenses' (p. 1002). There are several possible reasons for this, including the increased likelihood of the insured to seek care, a preference by the insured to prefer more expensive providers, and likelihood of medical providers delivering more expensive medical tests, drugs and interventions to the insured (Wagstaff & Lindelow, 2008).

China's healthcare challenges for the new millennium

China's performance as a leader in Asian health services has been deteriorating steadily since the early 1980s compared with other developing countries. China is now behind several other Asian nations, according to the World Bank, despite 'massive increase in total healthcare expenditures' (Ramesh & Wu, 2009). Its population is now rapidly aging compared with other BRIC (Brazil, Russia, India and China) countries. This is in part due to its one-child policy and in part due to low wages for many Chinese even as others are becoming economically prosperous (Cao, Chen & Fan, 2011). The number of people aged 65 or older is 8.3% of the population, or more than 109 million people (2009; Cao et al., 2011). By 2050, it is estimated that 25% of the total population will be senior citizens (Cao et al., 2011). Concerns are now surfacing in China about the inevitable 'intergenerational injustice' as the young voice their objection to potentially paying more for healthcare to offset costs of caring for the elderly as that population grows (Cao et al., 2011). Recent surveys show that healthcare costs and equity are among the top concerns among the public (Cao et al., 2011). Due to the public concerns, the Chinese government has recently made efforts to analyse the situation and put a plan into place to provide insurance to more citizens and increase equitable access to care (Ramesh & Wu, 2009).

In 2007, nine organisations (including the World Bank, World Health Organisation and Peking University) made formal recommendations for reforming the health system (Ramesh & Wu, 2009). Later, in a 2008 State of the Nation address, Prime Minister Wen Jiabao announced a 25% increase in health services spending by the government (Ramesh & Wu, 2009). Proposed measures include increased government expenditures to provide free or low-cost routine care at publicly funded hospitals, or increased funding to provide government-subsidised health insurance to the 80% of the population currently lacking health insurance (Ramesh & Wu, 2009). Although more public spending appears to be needed, it is unclear what, if anything, these measures will do to restrain the quickly growing cost of providing health services (Ramesh & Wu, 2009). The government has now committed to achieving universal health coverage by 2020 (Ramesh & Wu, 2009). ◆

Heather Mullins-Owens is the director of Global and Integrative Health at HERO Network LLC, a member of the Clinical Ethics Committee at Eskenazi Health Services, a research compliance consultant at Indiana University, and a PhD student at Indiana University's School of Health and Rehabilitation Sciences. She received her JD from the University of Dayton and her MA in bioethics from Indiana University. The above is extracted, under a Creative Commons licence, from an article published in SAGE Open *(January-March 2015, DOI: 10.1177/2158244015575187, sgo.sagepub.com).*

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Healthcare and financing in China under economic transition

CHINA'S gross domestic product (GDP) has grown rapidly in recent years (an average of 10.2% per year from 2000 to 2007). This growth is largely taking place in the industry and services sectors. Value added in these sectors (48% and 40% of GDP respectively in 2007) far outweighs the value added in agriculture (12% of GDP in 2007). Household consumption expenditure as a proportion of GDP is quite low by international standards (much lower than in India, Brazil and Russia), while gross capital formation has been very high by international standards; in other words, a relatively small proportion of profit and tax has gone to households; a relatively large proportion has gone to capital investment.

Average per capita gross national product (GNP) increased from $800 in 1990 to $6,020 in 2008. However, income inequality has widened greatly since the commencement of economic reform; the Gini coefficient rose from 0.31 in 1978/79 to 0.45 in 2004, similar to that of the USA. In 2000-07 around 16% of Chinese were living on less than $1 (international dollars) per day. Per capita GDP in 2000 varied from less than 5,000 RMB in Guizhou to over 25,000 RMB in Shanghai, with corresponding differences in life expectancy from 66 in Guizhou to 78 in Shanghai.

In terms of health development, the indicators are mixed. Aggregate data are good by international standards, with life expectancy in 2008 (74 years) well above the average for the high-middle-income countries (71 years). Under-five mortality is just below the average for the high-middle-income countries (21 per 1,000 live births compared with 23). Stunting among under-fives is comparatively high, at 21.8% in 2000-09. However, these average figures obscure wide variation, with child malnutrition three to four times more common in the rural areas than in urban areas. Maternal mortality in China is less than half the average for the high-middle-income countries (45 per 100,000 live births compared with 91).

China spends a relatively small percentage of GDP on healthcare (4.3% of GDP, $233 per head in 2007), with a high proportion of this being out-of-pocket expenditure (51% in 2007). There have been massive increases in government funding for healthcare since 2007.

In technical terms the breadth and depth of specialist tertiary care in the leading hospitals is world-class. However, poor people face significant price barriers to accessing care; resources are inequitably distributed; quality and safety are uneven; and there are significant inefficiencies in service delivery. Primary healthcare is poorly equipped, staffed by less well-trained practitioners and generally not trusted.

Healthcare financing and economic transition

Under the 'socialist planned economy' (1949-76) healthcare was a responsibility of the 'work unit', the factory or school or government department in the city and the collective farm or commune in the country. The work unit employed the primary healthcare staff (health centre or clinic) and larger enterprises also ran secondary hospitals. The work unit also contributed to the cost of tertiary care if employees accessed such care. The military and the railways and some other sectors administered their own hospitals. Hospitals were budget-funded and user charges were very limited. These arrangements were referred to as the Government Insurance Scheme, the Labour Insurance Scheme and the Cooperative Medical Scheme (CMS) in the country. Under the CMS the cost of primary healthcare (a part-salary for the barefoot doctor or village doctor) was met out of the general revenues of the collective farm or commune, and a small contribution could also be made to meet user fees if the patient needed attention in the township or county hospital.

These enterprise-based welfare arrangements ensured universal coverage at a relatively basic level. Healthcare was overwhelmingly provided at the primary level, with a small proportion of cases being referred to secondary hospitals and a very small proportion being admitted to tertiary hospitals. There was a much greater emphasis on doctors from tertiary and secondary hospitals actually travelling out to provide training and advice at the primary level than on patients moving from primary to secondary to tertiary. However, it was basic care. The village doctors were commonly six-month certificate-trained; the doctors in the clinics in the cities and in the hospitals in the country were largely secondary or tertiary diploma-trained. Only in the tertiary hospitals were bachelor-trained

doctors employed and in the early years there were very few of either.

With the commencement of economic reforms (from 1978), enterprise welfare came to be referred to as 'all eating from the common pot' and the reforms included 'smashing the iron bowl'. The main concern was not enterprise welfare per se; rather it was the low productivity of the planned economy. Pre-1978, enterprises were assigned staff, budget-funded and given output targets. Since the prices of inputs and outputs were all administratively determined and surplus revenue belonged to the administering ministry or bureau, there was no incentive to increase volume or reduce unit costs. The reforms sought to improve productivity by giving enterprise management greater discretion with respect to the procurement of inputs, the production process and output levels and keeping 'profit'. However, state-owned enterprises (SOEs) were still operating within a complex regulatory framework with staffing levels and prices closely controlled by different government authorities, which made the reform of production very slow.

During the 1980s it became clear that internal reform was not moving very fast and the focus shifted to corporatisation and competition, encouraging private enterprises, including joint enterprises with foreign firms, to compete with the newly corporatised SOEs. One of the big differences between the private enterprises and the SOEs was enterprise welfare. Unless the SOEs were able to reduce the 'burden' of education, housing, health and aged care for their employees, there was no way they were going to be able to compete with the new private enterprises. Smashing the 'iron bowl' became a necessary condition for the survival of the SOEs.

Another feature of the 'iron bowl' was secure lifetime employment. This was recognised by the reformers as a major brake on enterprise productivity with overstaffing, often inappropriate staffing (due to lack of hire power) and lack of management levers to encourage greater individual productivity (lack of firepower). It was also a major brake on labour mobility, a key prerequisite for efficiency at the system level. It was recognised by the policy-makers early on that the establishment of autonomous social 'sectors' (education, housing, healthcare and social security) and the divorce of welfare functions from employment were conditions for allowing greater labour mobility.

The move from a planned economy to a market economy had profound implications for government revenues. Under the planned economy government revenues were based on top-slicing economic transactions controlled by the state. Prices and volumes were controlled in accordance with the plan and the plan made provision for transfers to general government revenues. As the SOEs were required to compete with private enterprise within a market economy, SOE revenues came to depend more on market demand and market-determined prices and government revenues necessarily moved towards a greater dependence on formal taxation.

One of the earliest and most dramatic reforms was the return to family farming (following the collapse of collective farming). The return to family farming is widely regarded as part of the reason for dramatic improvements in farm productivity in the 1980s, which provided the basis, in terms of food and labour, for the spurt in industrialisation. However, the collapse of collective farming also led to a compete collapse of the funding base for rural healthcare, and it has taken almost 30 years for the policy-makers to put in place an alternative funding base (the New CMS or NCMS). During this time farming families have been largely without any form of health security while the costs of healthcare have escalated.

The demise of enterprise welfare and the winding back of micro-regulation of SOEs have also been long-drawn-out affairs and are far from finished. There was a long delay between the elimination of enterprise-based healthcare and the development of functioning health insurance. This commenced with the establishment of the Urban Employees Health Insurance Scheme (UEHIS) in the late 1990s. This was a contributory scheme (with employee and employer contributions) administered through the Labour and Social Security portfolio at the municipal level. This scheme extended the existing coverage of the Labour Insurance Scheme (covering SOEs) to other large employers. The UEHIS does not cover the informal sector and many small or struggling enterprises are allowed to remain outside the scheme. It does not cover rural migrants working in the cities, the 'floating population'. The benefit levels provided are limited and patients commonly face high out-of-pocket costs.

Over the last five years there has been a dramatic increase in government support: for rural healthcare (through the NCMS); for safety net provision for poor people through the Medical Assistance scheme (MA) and through budget support for urban community health. The NCMS, based largely on government funding, is moving towards universal coverage (including in some cases urban migrants), although the depth of cover remains thin with high out-of-pocket payments. The Urban Residents Insurance Scheme extends similar coverage and benefits to the floating population and the informal sector in the cities.

The necessary condition for the increasing flow of funds to healthcare over the last five years has been growth in GDP and the availability of resources. However, of comparable importance has been the rising concern in Beijing regarding 'social instability'. The Chinese government and the Chinese Communist Party are concerned that rising inequality, anger at corruption and frustration with the healthcare system could contribute to disaffection and instability. ◆

The above, extracted from Global Health Watch 3: An Alternative World Health Report *(2011), was written by David Legge, Chairperson of the People's Health Movement.* Global Health Watch 3 *was produced by People's Health Movement, Medact, Health Action International, Medico International and Third World Network, and published by Zed Books.*

The state and healthcare in Malaysia: Provider, regulator, investor

Despite underfunding the public healthcare sector, the state in Malaysia has managed to operate a fairly successful public healthcare system since the country became independent in 1957. But the state is also a preeminent investor in private commercial hospitals. The multiple and conflicting roles of the state coupled with moves to corporatise the public healthcare sector and a proposal for a national health insurance scheme threaten to hasten the emergence of a full-fledged two-tier health system.

Chan Chee Khoon

Universalistic entitlement to public sector healthcare

WHILE healthcare is not inscribed in the Malaysian constitution as a human right, Malaysian citizens have become accustomed to a de facto entitlement to tax-funded, publicly provided healthcare since decolonisation in 1957.

Presently, employees and pensioners in the public sector enjoy practically free access to government healthcare as an employment benefit. For non-civil servants, outpatient primary care in the urban areas entails a nominal payment of 1 Malaysian ringgit ($0.27) which covers consultations, necessary investigations and medicines. In the rural areas, there are no charges for government-provided primary care.

Patients who are referred to government specialist clinics are charged 5 ringgit for each outpatient visit. Inpatient care at government facilities is also highly subsidised, accounting for 74% of hospital admissions in 2008.

Almost 90% of the Malaysian population live within 5 km of a primary healthcare facility. In addition to vaccinations, pre-natal and post-natal care, maternal and child health programmes, primary medical care with referral backup, health awareness and promotion, and vector control of communicable diseases, the Rural Health Service also covers potable water supply, sanitary latrines, environmental hygiene, and food and nutritional supplements.

An underfunded public healthcare sector

This extensive coverage and universalistic entitlement[1] to publicly provided healthcare has benefited a large fraction of the Malaysian population. But the modest expenditures also impose limits on the level, timeliness and (perceived) quality of care that can be delivered, and furthermore translate into modest staff salaries in the public healthcare sector.

In 2009, government healthcare expenditures amounted to 2.71% of gross domestic product (GDP), while private spending added another 2.25%. Overall, user charges for the government-provided services amount to 2-3% of the Health Ministry's actual expenditures. Notwithstanding these modest health outlays, life expectancy in 2012 was 75 years, and the under-five mortality rate was 9 per 1,000 live births.

At the present time, the government healthcare sector receives a yearly infusion of newly graduated doctors who are required to serve a four-year mandatory national service inclusive of the internship period.

As a result of push and pull factors, there is a perennial exodus of senior experienced staff from the public sector. The outflow of government doctors, nurses, specialists and technicians sets off a vicious cycle, as the understaffing translates into heavier workloads for those who remain, thereby further reinforcing the push factors. Meanwhile, the unrelenting promotion of medical tourism since the late 1990s adds to the lure of private practice which increasingly services a clientele that is regional in scope.

Corporatising the public healthcare sector

In 1999, the Malaysian government announced a plan to corporatise its hospitals and other healthcare facilities, in part to stem the outflow of health professionals. The corporatised institutions would remain publicly owned but would be vested with more managerial discretion in matters of salary scales, patient fees, procurements, and responsiveness to market demand and clients' preferences. Coming in the wake of the outsourcing of hospital support services and pharmaceuticals supply, however, it aggravated public anxieties that clinical and hospital services would in due course be privatised too. This quickly became an emotive issue in the run-up to the general elections of November 1999, and was eventually shelved.

Eight years passed before the issue re-emerged in the form of opportunities for limited private practice in

government hospitals. Selected public hospitals with treatment facilities for liver-related illnesses, hand surgery, breast cancer and endocrine diseases began to offer to 'full-paying patients' preferential access to consultation and treatment by specialists of their choice, in an executive or first-class facility, and to be charged accordingly.

The Coalition Against the Privatisation of Health Services[2] has consistently opposed such arrangements for private wings or private patients on the grounds that:

• only 30% of specialists were employed in the government sector, but they served 70% of hospital admissions throughout Malaysia

• in addition to their clinical and ward duties, specialists had teaching, training and mentoring responsibilities towards their junior colleagues in the public hospitals

• the full-paying patient scheme would unavoidably claim disproportionate attention and priority and would compromise further the quality of services received by the regular patients, overburdened as the system was by chronic understaffing of specialists in the government sector.

Interestingly, the Association of Private Hospitals of Malaysia (APHM) was also opposed to the private wings proposal, perceiving a threat of price competition from a subsidised and publicly owned service that was not solely intent on maximising profits.

Equally interesting was the ambivalence of the health insurance industry vis-à-vis private healthcare providers. Deteriorating public hospitals reinforce people's felt need for private health insurance, but health insurers also complain endlessly about moral hazard and price gouging by private providers so much so that they make incentive payments to policy holders to access the public hospitals when in need of care. Going by their rhetoric, they want low-cost, no-frills, 'medically necessary', evidence-based care, which sounds engagingly like the original progressive vision of managed care. Under certain circumstances, they might even be supportive of subsidised, publicly provided healthcare with moderate user charges or co-payments.

The state as entrepreneur in healthcare

In 1979, the corporate arm of the provincial government of Johor state launched its first commercial hospital. Over the next 25 years, this inaugural venture grew into the largest chain of private hospitals in Malaysia, KPJ Healthcare (26 hospitals in Malaysia, with another two in Indonesia). Indeed, KPJ is now a public-listed healthcare conglomerate which offers not just inpatient care but a diversified portfolio of services including hospital management, hospital development and commissioning, basic and post-basic training for nurses and allied health professionals, laboratory and pathology services, central procurement and retailing of pharmaceutical products, healthcare informatics, and laundry and sterilisation services.

Meanwhile, the federal government's sovereign wealth fund Khazanah Nasional began acquiring domestic and foreign healthcare assets in 2006. By 2012, its healthcare subsidiary IHH Healthcare had emerged as the second-largest listed healthcare provider in the world (by market capitalisation, $8.06 billion), after the Hospital Corporation of America (HCA). With its 37 hospitals and 6,000-plus beds (2014), IHH has expanded beyond its home markets in Singapore, Malaysia and Turkey to China, Hong Kong, India, Brunei, Vietnam, United Arab Emirates, Macedonia and Iraq as well.

Domestically, these developments mean that the Malaysian government, in concert with government-linked companies (GLCs)[3] at both federal and state levels, effectively own or operate three parallel systems of healthcare providers in Malaysia:

• the regular Health Ministry facilities

• corporatised hospitals (National Heart Institute, university teaching hospitals)

• a huge 'private wing': the KPJ and IHH chains of commercial hospitals.

The ambiguity of public and private

This fusion of state and capital in the healthcare sector is rife with conflicts of interest as the state – wearing multiple hats – attempts to reconcile sometimes divergent priorities in the public and private healthcare sectors. As Khazanah comes under pressure for instance to secure commensurate returns from its costly acquisition of private healthcare assets, will the public sector suffer from a benign neglect? Will the poaching of public sector staff by the private sector continue unabated, or will it be subject to some restrictions? What safeguards will be put in place for impartial regulation, given the potential for regulatory conflicts of interest in the healthcare sub-sectors?

The attempted acquisition of Institut Jantung Negara (IJN, National Heart Institute) by Sime Darby Ltd in 2008 is a revealing instance of these disparate interests.

In 1992, IJN was hived off from the Kuala Lumpur Hospital and corporatised as a government-owned referral heart centre. One of the missions of this 430-bedded hospital was to provide high-quality services in cardiovascular and thoracic medicine at medium cost. The federal government would continue to subsidise IJN although not to the extent of 90-95% as was commonly the case for the regular Ministry of Health facilities.

The intention was that IJN should also act as a price bulwark, i.e., a more affordable fallback option which could help restrain escalating charges at private hospitals such as the Subang Jaya Medical Centre (SJMC).

In December 2008, Sime Darby, the controlling stakeholder of SJMC and one of the largest GLCs in Malaysia, submitted a proposal to the Ministry of Finance to acquire a 51% stake in IJN. The federal cabinet initially responded positively towards the proposed acquisition, despite widespread apprehension.

An investigative report by *The Star* (18 December 2008) duly noted that IJN charges for procedures such as coronary bypasses and angioplasties were 25-50% lower than the corresponding charges at SJMC.

Evidently, Sime Darby, by acquiring IJN, hoped to establish a commanding presence in a lucrative medical specialty, and at the same time to absorb and thus neutralise a lower-priced competitor.

Amidst mounting public opposition, the proposal was eventually dropped by the cabinet.

Targeting: The persuasive face and generic template for privatisation

As Malaysia's government-linked entities built up their stakes in the commercial healthcare sector, a succession of health ministers have argued – using a rhetoric of targeting – that Malaysians who could afford it should avail themselves of private healthcare services (suitably encouraged thus with income tax rebates). This would allow the government to target its limited healthcare resources at the 'really deserving poorer citizens'. Seen in that light, 'targeting' can therefore also be the persuasive face and generic template for the commercialisation of essential social services.

This intuitively appealing logic however ignores the consequent poaching of staff from the public sector, which exacerbates the already burdensome workload of its remaining staff, thus feeding into a self-reinforcing downward spiral. Identifying and tracking the 'targeted eligibles' (means testing etc) would furthermore entail administrative and transactional costs that are unnecessary with a policy of universal entitlements. Most importantly, a policy of selective targeting would detach a politically vocal, well-connected and influential middle class from any remaining stake in public sector healthcare, hastening the arrival of a rump, underfunded, decrepit public sector for the marginalised classes.

National health insurance?

Is there an alternative to this emerging two-tier healthcare apartheid? The Malaysian government's answer to this is a proposed national health insurance scheme designated as 1Care. This would entail mandatory employer and employee contributions to a publicly managed health insurance fund, along with patient co-payments and supplementary federal allocations, which would finance a defined benefits package. Among other things, 1Care was envisaged as a vehicle which could open up access to underutilised capacity and specialist expertise in the private health sector, subject to a standard fee schedule applicable to all providers. Would private facilities and private practitioners be allowed to opt out of the scheme, if they chose to concentrate on more lucrative niche markets (e.g., affluent patients and medical tourists)? Or would they be prevailed upon to undertake their 'national service', given the pervasive public ownership of the for-profit healthcare sector?

An alternative scenario, which relies on more progressive taxation regimes to improve universal access to quality care on the basis of need, which dispenses with much of the administrative and transactional costs of managing 1Care's eligible pool of beneficiaries and its provider payment systems, is notably absent from the options under consideration.

Regulatory environment

Given the dominant presence of GLCs in the commercial healthcare sector (accounting for more than 40% of private hospital beds), the independence and impartiality of state regulatory agencies in this sector may be challenged.

The Medical Act (1971), which created and empowered the Malaysian Medical Council (MMC) to register accredited medical professionals and to oversee standards of professional practice, also designates the Director-General of Health as the chair of the MMC. Because the current regulations do not bar retiring senior government officials from taking up positions in organisations over which they exercised regulatory authority, two retired D-Gs of Health have gone on to be presidents of private medical universities in Malaysia. Indeed, one of them also chairs the board of directors of IHH Healthcare.

Other retiring senior officers have taken up leading executive positions at agencies which monitor the performance of concessionaires which have been awarded outsourcing contracts for hospital support services.

Notwithstanding the Health Ministry's regulatory powers over the location of new private hospitals (Private Healthcare Facilities and Services Act, 1998), it has yet to exercise this discretion to prioritise underserved areas to improve the spatial dimension of health equity.

This Act also empowers the Health Minister to regulate professional charges for consultations and procedures performed by doctors, but not the charges levied by private hospitals for usage of ward, operating theatre, other institutional facilities, nursing time, medical disposables and treatment accessories. Hospital charges are exempted from the goods and services tax (GST) introduced in 2015, unlike the professional fees of (non-salaried) attending doctors. Hospitals also receive 10-15% of the professional charges as an administration fee.

Conclusion

The Malaysian state has an unusual characteristic born of its recent history. In 1970, in the wake of post-election ethnic rioting and a brief period of emergency rule, a New Economic Policy (NEP) was promulgated with the twin goals of reducing poverty and reducing inter-ethnic disparities, most notably between the predominantly Malay indigenous (bumiputra) community and a sizeable ethnic Chinese minority. One of the indicative targets of the NEP was to increase the bumiputra ownership of incorporated share capital from 2.4% in 1970 to 30% by 1990.

Given the small size of the Malay business and shareholding class at the time, this ambitious task of restructuring share ownership inevitably fell to the state. Bumiputra trust agencies were duly created to acquire and to manage massive holdings of corporate equities, from which were spawned unit trust funds which could reach a broader base of eligible bumiputra beneficiaries. In parallel with these initiatives were efforts to foster the emergence of a bumiputra commercial and industrial community (BCIC, i.e., a Malay bourgeois elite) which could take on leading roles in a diverse range of government-acquired or government-spawned commercial enterprises.

Within two decades, Malaysian government trust agencies and GLCs had acquired sizeable if not controlling stakes in the commanding heights of the national economy (finance and banking, plantations and agribusiness, oil and gas, heavy industry, media and broadcasting, infrastructure and construction, power generation and distribution, postal services and telecommunications, transportation, leisure and hospitality, among other sectors).

In this manner, the Malaysian state, going beyond its more traditional welfarist and developmentalist roles, took on the character of an entrepreneurial state as well.

In this article, I have described in some detail the state's ventures into for-profit healthcare by governmental entities at both federal and state (provincial) levels. The salient points which have emerged are the following:

• The state is juggling multiple hats: (i) as funder and provider of public sector healthcare, (ii) as regulator, and (iii) as pre-eminent investor in for-profit healthcare, along with the inherent conflicts of interest.

• Public sector healthcare is woefully underfunded and is plagued by a chronic shortage and continuing outflow of senior experienced staff, thus affecting the quality of its care and its ability to restrain the escalation of charges in the private sector.

• Whether there is a de facto policy of benign neglect of the public sector is unclear, but a succession of health ministers have argued that those who can afford to should avail themselves of private healthcare, so that the government can conserve its modest resources for the 'truly deserving poor'.

• This seductive logic (of the targeted approach) will hasten the arrival of a two-tier healthcare system: deluxe priority care for the rich, and a rump, underfunded public sector for the rest.

• The alternative scenario, a more progressive taxation regime to improve universal access to quality care on the basis of need, seems to be off the radar screen (hobbled in part by public scepticism over the unaccountable stewardship of public financial resources).

• The potential for regulatory conflicts of interest (regulatory capture, the 'revolving door') has not been addressed.

• There is little evidence that the state is exercising its ownership prerogatives in commercial healthcare enterprises to pursue a balance of social vs. pecuniary objectives (e.g., cross-subsidies, playing a price-restraining role in the manner envisaged for IJN) beyond cosmetic 'corporate social responsibility' initiatives.

It is far from clear that these developments amount to a progressive 'nationalisation' of private enterprises in essential human services, rather than an infusion of the ethos and logic of capital into the institutional dynamics of the state.

While there is considerable room for improvement in Malaysia's public healthcare system, its widely accessible services are nonetheless a remarkable and underrated achievement in Malaysia's developmental history. Amidst the shifting patterns of ownership and clienteles of this healthcare system (the ascendant role of GLCs in commercial healthcare, the possible emergence of social health insurance, the push for medical tourism, etc.), however, it is likely that a pluralistic healthcare system will continue to exist into the foreseeable future. A crucial role for government must therefore also include the oversight and regulation of an evolving system of healthcare provision and financing such that all Malaysian citizens (and other eligible beneficiaries) continue to enjoy access to equitable healthcare on the basis of need, not on the basis of ability to pay (at the point of service), i.e., a de facto human right to (medically necessary) healthcare.[4] ◆

Chan Chee Khoon is a health systems and health policy analyst at the Centre for Poverty & Development Studies, Faculty of Economics & Administration, University of Malaya. He has contributed and reviewed chapters for Global Health Watch.

Endnotes

1 Malaysian citizens may or may not avail themselves of this universalistic entitlement, but even those who do not do so benefit from its second-order effects, insofar as the availability of subsidised publicly provided healthcare (of a certain quality) acts as a fallback option – a restraining price bulwark – which helps to keep private healthcare charges within a more affordable range.

2 A coalition of 70 non-governmental organisations that came together in 2005 to campaign against the privatisation of publicly provided health services.

3 GLCs are defined as companies that have a primary commercial objective and in which the Malaysian government has a direct controlling stake (i.e., ability to appoint board members and senior management, make major decisions for the GLCs including contract awards, strategy, restructuring and financing, acquisitions and divestments etc.) either directly or through government-linked investment companies.

4 The right to health in a national context often translates into citizen entitlements. This leaves migrants and refugees falling through the cracks, in a region (South-East Asia) which is home to major labour-exporting and labour-receiving countries. This is a major issue of regional social policy which requires sustained regionally coordinated advocacy to advance migrants' and refugees' rights to health and well-being.

The health crisis in Europe

The eurozone crisis and the accompanying increase in public debt is being used as an argument to push for privatisation, thus transforming healthcare into a marketable commodity. The following article describes the myriad pathways through which public services in healthcare are being undermined across Europe.

THE responses in Europe to the global economic crisis have been based on strengthening of market mechanisms, combined with the encouragement of competition between countries through reduced production costs (by lowering labour costs) and social dumping. The consequences of these measures are manifested in the form of decreasing purchasing power of the population, declining public investment and a steady breakdown of social protection mechanisms.

Available evidence clearly points to a breakdown or reversal of social security systems across Europe. Between 2008 and 2011, the unemployment rate for the European Union (EU) rose from 7.1% to 10.7%. Adverse effects on young people have been particularly prominent – by September 2012, 22.8% of economically active people between 15-24 years were unemployed.[1] In 2011, more than 24.2% of the EU's population were at risk of poverty, and one-third of the poor were the 'working poor'.[2]

The economic crisis and the accompanying increase in public debt (i.e., debts incurred by governments) is being used as an argument to push for privatisation, thus transforming healthcare into a marketable commodity. In the beginning of the economic crisis, a World Health Organisation (WHO) report in 2009 had already warned that 'some countries are at particular risk … and these include developed countries that have required emergency assistance from the IMF [International Monetary Fund], where spending restrictions may be imposed during loan repayment'.[3] A study conducted by the European Foundation for the Improvement of Living and Working Conditions in several countries across Europe depicts the myriad pathways through which public services in healthcare

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The *marea blanca* (white tide) movement has mobilised opposition to privatisation of healthcare services in Spain.

are being undermined across Europe.[4] The study, inter alia, points to the following trends:

• Since 2007, almost all EU member states have experienced reductions in public expenditure on healthcare.

• Sections of people in most of the countries studied have experienced reduced availability of healthcare services because nearby service providers have closed due to the crisis. Some have been closed as a result of explicit, top-down government decisions. Others have closed because reduced reimbursement of the services they provided and reduced income from patients made them unviable.

• Besides budget cuts and caps, delays in receipt of public funds by healthcare providers have also been identified as an impact of the crisis that has threatened continued service delivery and thus access.

• Even where the nearest healthcare service provider has remained open and its budget was not cut, people have experienced reduced accessibility due to decreased public investment in transport or reduced ability to pay for the service.

• People have also experienced reduced availability of services because of staff cuts and limits on hiring new staff.

• In countries with social health insurance systems, unemployment has led to a loss of insurance coverage for sections not entitled to free insurance. Further in countries with health insurance systems, it has become more difficult for some groups to make health insurance contributions.

• The share of healthcare costs which patients need to pay up front for treatments has increased in many countries for several types of services.

• In several countries there is evidence of a shift in the direction of public funding and provision because people cannot afford private care anymore. This leads to greater demand for public services, a greater reliance on public funding and fewer resources for service providers.

There is mounting evidence from other sources that indicates the gravity of the health crisis, brought on by

austerity measures as a response by EU governments to the economic crisis.

Greece: the face of the health crisis in Europe

In Greece, the economic recession and the austerity measures imposed in the country by the troika – European Commission, IMF and European Central Bank – triggered a sharp deterioration in the socio-economic conditions of the working class and even sections of the middle class. It is estimated that 3.9 million Greeks (out of a total population of 11 million) were living below the official poverty line by the end of 2013[5] and the unemployment rate stood at 27.3% in 2013.[6] The infant mortality rate increased by 51% between 2008 and 2011; and suicide and homicide mortality increased by 11.5% and 40% respectively between 2007 and 2010.[7] Concurrently, private health expenditure in Greece decreased by 16.2% between 2008 and 2010, reflecting the inability of households, in times of crisis, to purchase health services even in a situation where the public system is crumbling.

At the same time, the demand for public healthcare services has increased since the advent of the crisis. The growing demand on healthcare facilities is reflected in an increase of 36%, between 2008 and 2012, in the number of hospitalised patients (Greek Ministry of Health, 2012). Paradoxically, austerity measures imposed by the Greek government restricted free access to healthcare services. Restrictive policies included a decrease in funding and a downsizing of public health services, higher user fees and cost-sharing. Between 2009 and 2011, the total expenditure of the Greek Ministry of Health decreased by €1.8 billion. On the other hand, in 2011, patients spent €25.7 million on out-of-pocket payments for outpatient services in public hospitals – services that had been free at the point of use before the crisis.[8] Further, from 2009 to 2011, the number of people reporting inability to visit a doctor owing to economic hardship or long waiting lists increased by almost 50%.

As health insurance coverage was available only to those who work for more than 50 days per year, it left out major sections of the population, including the unemployed, casual workers and irregular immigrants; 2.5 million people in Greece are without any form of health insurance coverage (2014 data from the Greek Ministry of Labour). The current situation points to a fundamental flaw in the way public healthcare services have traditionally been funded in Greece. Historically, the social insurance funds were linked to employment, and this worked fairly well when unemployment rates were low. However, faced with the present crisis and the huge rise in unemployment, the system is on the verge of collapse and the assets of social insurance schemes have decreased dramatically. Clearly, there is a need to organise public health services and their financing in a manner that doesn't entirely link access to healthcare with conditions of employment.

The restructuring of public health services is being driven by conditionalities imposed on Greece as part of the austerity programme. From 2010 to 2013, 170 conditionalities related to healthcare were included in the memorandums of understanding signed by the Greek government and the troika. These include budget caps, introduction of multiple user fees, freezing recruitment of staff, and substantial reductions in health workers' wages and in the social security funds' healthcare benefit packages.[9] Also included were various measures on healthcare reforms that promote the establishment of an internal market in public health services, and ultimately lead to the privatisation of these services.

Manifestations of the health crisis in different parts of Europe

In the UK, the government has allowed corporations to enter the arena of healthcare by implementing a series of incremental and far-reaching legal changes designed to allow the entry of capital.

In Portugal, public spending declined by 8% in 2011, after having remained stable between 2009 and 2010. The national health service is under siege; important parts of the public sector have been privatised and many health workers are losing their jobs.[10] Co-payments for healthcare have gone up drastically, causing a decrease of 900,000 first-line consultations and half a million emergency consultations between January and October 2012 compared to the year before, while 'rationalisation' of medicine use has led to significant increases in cost to patients.[11] A study conducted in May 2012 showed that 22.2% had reduced their health expenditures. In families where one or more members were unemployed, the figure was 39.9%. The crisis is having its most dramatic impact on mental health. Between 2011 and 2012, diagnosis of depression increased by 30% in the north of the country, and in the same period, suicide attempts grew by 47% among women, and by 35% among men.[12]

In Italy, the growth in health expenditure between 2000 and 2010 was the lowest among the 34 OECD countries, yet savage health budget cuts have been imposed (projected to be €25-30 billion during 2012-15). This is resulting in increased user fees, removal of healthcare benefits, reduction in specialist care and decreased access to care – particularly for vulnerable socio-economic groups.[13] In 2011/12, the overall expenditure for drugs decreased by 5.6%. While public healthcare expenditure decreased by 8%, private expenditure increased by 12.3%. A sharp increase in user fees for drugs (117.3% between 2008 and 2012) has contributed to this.[14] In a recent survey, 10% had postponed surgical treatment for financial reasons and 26% reported increased expenditure for medical emergencies due to higher co-payments.[15] People are shifting increasingly to the private sector, which is not surprising considering that 27% say that they have paid higher fees in the public sector compared to the fees charged by the private sector for the same service. Even

more worryingly, 41.2% of Italians now consider the national health service as a safety net for essential services, and believe that all the rest should be purchased privately, and 11 million are covered by private insurance schemes.[16]

In Spain, the healthcare budget has declined by 18.21% since 2009.[17] Healthcare services have been cut, 53,000 health professionals have been removed from the public health system in the last three years, and user fees have been increased (including co-payments for medicines). The earlier universal entitlement to access to the public health system has been replaced by employment-based entitlement, thus excluding large population groups (e.g., approximately 900,000 undocumented migrants, who are now entitled only to emergency care and maternal and childcare). As a consequence, quality of services has declined and out-of-pocket expenditure on healthcare has increased. There is a rise in waiting lists for patients who require major procedures – in 2010, 50,705 patients were on the waiting list for surgical interventions, while in 2013 their number had increased to 89,000. National and regional governments are using budget cut targets to force the privatisation of the Spanish healthcare system – 236 out of 550 acute care hospitals are now private.[18]

While the German economic model is presented as a success story, 16% of the German population live in poverty and almost five million workers have 'mini-jobs' with a monthly salary of €400. The 8% increase in employment between 1996 and 2011 is due to an increase in working hours and also related to an increase in part-time employment without social security rights;[19] 26% of jobs in Germany are precarious (temporary contracts, part-time jobs, etc). Eight million workers (23% of the country's workforce) lived in poverty in 2010, and this included 50% of workers with full-time jobs.[20] In 1998, the poorest 50% of the population possessed only 4% of Germany's wealth and this plummeted to 1% in 2008.

Germany has also seen one of the largest waves of hospital privatisation in Europe. Between 1995 and 2010, the proportion of private hospitals doubled while at the same time the total number of hospitals fell by 11%.[21] The share of cases treated in private hospitals grew from 5.2% in 1995 to 9.1% in 2003, and further to 16.1% in 2010.

Since the 1990s, Belgium too has cut back on investments in public healthcare infrastructure and social security. From 1997 to 2005, out-of-pocket payments for healthcare rose from 23% to 28% and this has had catastrophic effects. In 2007, about 14% of the Belgian population reported having postponed necessary care because of financial problems (compared to 8% in 1997 and 10% in 2004).[22]

Resistance against neoliberal reforms in Europe

Across Europe the neoliberal reforms are not going unchallenged. The moves to privatise healthcare services face resistance from both popular movements of civil society and workers in the public healthcare system. In Spain, a historic unity, linking the entire range of health professionals (doctors, nurses, health workers), has resulted in the organisation in Madrid and other regions of a huge movement, called '*marea blanca*' (white tide). The movement has organised a prolonged strike and massive street protests. In the face of these struggles, in January 2014 the conservative government of the region of Madrid cancelled its planned outsourcing of management and services at six local hospitals. If implemented, the plan would have transferred six public hospitals to private healthcare management groups, adversely affecting the healthcare of 1.2 million people and the careers of 5,000 health workers.[23] While this has been a small victory, *marea blanca* warns that the protests should not stop, since a large part of the regional healthcare services is now managed or owned by private firms.

In Portugal, since the onset of the crisis, four general strikes and a series of national mobilisations involving all sections of the population have been organised to protest against privatisation of health services. These include a strike by doctors in July 2012 which saw the participation of over 80% of health professionals,[24] and street protests and demonstrations in September 2012 by hundreds of thousands in all big cities of the country.

In the UK, several public campaigns targeted the top-down reorganisation of the National Health Service (NHS). An organisation called Keep Our NHS Public, which is a network of several local affiliates, has been at the forefront of this campaign.[25] After the comprehensive reform of the NHS was pushed through by the government in 2012, a group of health professionals decided to create a new political party to challenge the health reforms at a political level. The National Health Action party is set to challenge the privatisation of the NHS and the fragmentation of care accelerated by the Health and Social Care Act, and aims to restore the NHS to a service that provides publicly funded healthcare free to all at the point of need.[26]

In Belgium, efforts are under way to develop a coordinated campaign against the privatisation of healthcare. The Action Platform for Health and Solidarity brings together trade unions and grassroots organisations.[27] It is also an endeavour to unite the resistance to neoliberal reforms in the health sector at a European level (Brussels being the main seat of the European Commission). In February 2014, the Platform organised a day of protest followed by an international conference of the European Network against Privatisation and Commercialisation of Health and Social Protection. The Platform has released a campaign manifesto against the privatisation of healthcare and for the promotion of a comprehensive, non-commodified healthcare system based on equal access.[28]

In Germany, 'Blockupy' protests – promoted by radical anti-capitalist political groups and networks – took place mainly in Frankfurt in 2012 and

2013 and are poised to continue, drawing increasing participation every year.[29]

A rising tide of protests, demonstrations and mobilisations confronted the planned dismantling of the public health system in Greece. Massive gatherings laid siege to administrative offices of public hospitals, protesting against the levy of a €5 registration fee for outpatients. In March 2014, primary healthcare doctors, administrative personnel and patients 'occupied' several primary healthcare centres to protest against the closure of 380 units by the Health Ministry. In parallel, solidarity movements were assembled to protect the growing number of jobless people who were being excluded from public health insurance schemes, and solidarity clinics were organised all over the country. These clinics combined solidarity and mobilisation of both health workers and patients against the policies denying healthcare access to millions of people.

Solidarity in the midst of crisis

The evidence from post-crisis Europe, especially as regards the major changes that have taken place in healthcare services, is 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 needs to be ramped up. The question may be asked: who would pay for enhanced investment in social protection measures? In large parts of Europe the public debt is extremely high and mounting. Yet there remain islands of extreme affluence within Europe – 3.2 million families have a combined wealth of €7.8 trillion. A tax on the financial wealth of the richest 2% could yield €100 billion every year.

There are moments in history when social logic must take precedence over other considerations. Europe stands at the crossroads today. Large parts of the continent stand to lose the benefits of social security that were won through many decades of struggles waged by the working people. To argue for a health 'commons' is to guide health workers and activists towards new ways of engagement and resistance, of participation in the struggle to protect and animate the public sphere. As noted by Stuckler and McKee: 'There is an alternative: public health professionals must not remain silent at a time of financial crisis.'[30] ◆

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Leaders commemorate 60th anniversary of Bandung conference

In April 1955 leaders of a number of developing countries from Asia and Africa gathered in the Indonesian city of Bandung for a conference which was to be the precursor of the Non-Aligned Movement. *Martin Khor,* who attended the 60th anniversary commemoration of this historic conference, reports on its proceedings and highlights its significance.

ON 24 April I took a 10-minute walk from an old hotel to another old building, a conference hall. About 300 others were in the same walk on the warm and sunny day.

It didn't seem anything remarkable or newsworthy. But this was no ordinary walk. Sixty years ago, on this same date, a small but powerful group of men and women took the same walk and then launched a movement that snowballed into a united anti-colonial and post-colonial battle.

Indonesian President Joko Widodo speaking at the summit in Jakarta held to mark the 60th anniversary of the Asian-African Conference which took place in Bandung.

We had come to commemorate and celebrate the anniversary of the Bandung conference of Asian and African leaders, all of whom had just won independence or were on the verge of doing so. The same grand Savoy Homann hotel was where the leaders had stayed, and they had taken the historic short walk on the Asia Africa Road to the Merdeka Building.

Bandung on 24 April 1955 saw giants like Sukarno of Indonesia, the host, Zhou Enlai of China, Jawaharlal Nehru of India, Gamal Abdel Nasser of Egypt, U Nu of Burma and some leaders of Africa coming together to discuss the need for newly independent countries to unite and fight for their common interests. They adopted the Bandung principles that included respect for national sovereignty and self-determination, equality of all nations, and abstention from use of force or exerting pressure on countries.

Bandung 1955 was the first-ever meeting of the developing countries, which pledged to help other countries still under colonialism to complete their independence struggle, and to cooperate to develop their poor economies. That Bandung spirit led to the formation of the Non-Aligned Movement in 1961, and indirectly also led to the Group of 77 in 1964, the two major umbrella organisations of the developing countries.

On 24 April 2015, political leaders from over 40 countries, led by Indonesian President Joko Widodo, and officials from international organisations walked from the Savoy Hotel to the Merdeka Building and took part in a brief but meaningful commemoration ceremony. Among the leaders present were the presidents of China, Zimbabwe and Myanmar, and the prime ministers of Malaysia, Nepal and Egypt.

We were told the Merdeka Building had not changed and that the chairs were the same as the ones used 60 years ago.

Widodo invoked the memory of the leadership and spirit of the giants of old, who had pioneered their nations' independence and forged unity among the newly independent countries.

In a two-day Asian-African summit conference in Jakarta preceding the Bandung ceremony, even more leaders were present to discuss the theme 'South-South Cooperation for Peace and Prosperity'. President Widodo made a strong speech highlighting the continuing power in-

Chinese premier Zhou Enlai and his delegation taking part in the historic walk from the Savoy Homann hotel to the Merdeka Building on the occasion of the Bandung Conference in 1955.

equalities and injustices in the world, in which developing countries were still struggling to get their rightful fair share in decision-making in world affairs.

Global injustice is obvious when wealthy nations think they can change the world with their might, when the United Nations is powerless, and the use of force is employed without the mandate of the UN and powerful countries ignore the existence of the UN, he said. Injustice exists when the rich countries refuse to recognise the shifts in world economic power and only recognise the World Bank, the International Monetary Fund (IMF) and the Asian Development Bank, he added. 'The fate of the global economy cannot be left to these three organisations, we need to build a new world order that is open to new countries. A new and fair global system is needed.'

Widodo also stressed that as the Bandung spirit demanded independence for countries, we are still indebted to the people of Palestine. 'We have to struggle with them to give birth to an independent state of Palestine.'

The plight and struggle of the Palestinians became a major issue at the summit. It was obvious that the continuing occupation of Palestinian lands and their unfulfilled fight for an independent state was a big piece of 'unfinished business' of the Asian-African Bandung conference. A special declaration in support of Palestine was adopted by the conference.

Two other documents adopted were the Bandung Message and the new Asia-Africa Strategic Partnership, which details the actions that are to be taken to promote more cooperation in economic, health, food security, education and other areas.

President Xi Jinping of China pledged to provide places for 100,000 students and officials in Asia and Africa for education and training in his country over five years. He put forward several principles, including to seek common ground and be open to one another's views; expand South-South cooperation, and the closing of the North-South gap. He also mentioned the new Chinese initiatives of setting up the Asian Infrastructure Investment Bank as well as a new fund to finance the activities of the Economic Silk Road and the Maritime Silk Road.

These initiatives by China are a reminder that with the growing wealth of China and some other emerging economies, there is now a real possibility for the developing countries to help one another in financing their own development. A new trend in South-South gatherings is that criticism of the ways of the West in dominating the South is now combined with announcements of how the developing countries are organising various ways to rely more on one another, including creating new institutions.

In a speech representing the South Centre, I mentioned that we support the call by the Indonesian President for establishing a new world order where the developing countries have an equal say and enjoy their fair share of the benefits. In this new and more equitable world order, the developing countries will be able to contribute to the solutions to the multiple crises of global finance and economy, food security, unfulfilled social development, energy and climate change.

The developed countries will change their unsustainable patterns of production and consumption, and assist the developing countries through financial resources and technology transfer to embark on new sustainable development pathways. South-South cooperation, based on solidarity and mutual benefits, will play an increasingly important role. There is much to be done politically and concretely in this area.

Bandung 1955 was a landmark event that launched many good developments for the newly independent countries. Bandung 2015 could also prove to be a landmark event that catalyses further breakthroughs in South-South cooperation which, together with our better performance in multilateral relations, will implement the building of the new world order that our first generation of leaders were dreaming of.

As the Jakarta and Bandung events came to a close, Indonesian officials indicated that they will be undertaking follow-up actions after the summit. It is important that concrete programmes are formulated, so that the well-intentioned declarations do not remain only on paper but spark new shoots of South-South cooperation. ◆

Martin Khor is Executive Director of the South Centre, an intergovernmental think-tank of developing countries, and former Director of the Third World Network. This article was first published in The Star *(Malaysia) (27 April 2015).*

Bandung in Latin America: The hope for another world

Latin American countries were not invited to the 1955 Bandung Conference, possibly because they were all out of sync with the dominant anti-imperialist stance adopted by the newly emerging African and Asian nation states which participated in this historic conference. *Roberto Bissio* reflects on the astonishing transformation that has taken place in the continent since then, which has made it possible for it to make common cause with Afro-Asia.

LATIN America was not in Bandung. It was not invited.

Sixty years on, as a Latin American I feel excluded.

I read with envy the passionate description by African-American journalist Richard Wright in *The Colour Curtain* of how 'the streets were packed with crowds and their black and yellow and brown faces looked eagerly at each passing car, their sleek black hair gleaming in the bright sun, their slanted eyes peering intently, hopefully, to catch sight of some Prime Minister, a U Nu, a Chou En-lai, or a Nehru...'.

It makes me want to have been there at what Wright sensed was 'an important juncture of history in the making ... Lenin had dreamed of a gathering like this, a conglomeration of the world's underdogs ... and many Western writers ... had long predicted the inevitable rise of these nations, but in their wildest intuitive flights they had never visualised that they would meet together in a common cause'.

I feel that I should protest to the Group of Colombo, the organising committee of the Bandung Conference, formed by Indonesia, Burma, Pakistan, Ceylon (Sri Lanka) and India. If 'colour' was the criterion for invitation, why not invite Latin Americans, who are a variety of mixes of indigenous people (actually early migrants from Asia), Afro-descendants, Arabs, Japanese (at least four million in the megalopolis of Sao Paulo), Javanese (in Suriname), Indians ('East Indians') in the Caribbean and Chinese along the Pacific coast?

Indonesian President Sukarno delivering the opening address at the 1955 Bandung Conference. The Conference saw no Latin American representation.

I would probably be told that Bandung was an Afro-Asian conference and therefore off-limits to Latin America. But in that case, why wasn't South Africa invited? Or Israel? Or either of the Koreas?

I can imagine the Colombo Group members saying, 'Can't you see that the presence of any of those would have derailed Bandung?' After all, diplomacy, like politics, is the art of the possible.

And on second thought, I can agree that there were good reasons for not inviting Latin America.

On the one hand, whatever the colour of its peoples, Latin American governments at that time were invariably formed by members of an elite that self-identified as 'white'. Just as the white settlers in Rhodesia proclaimed independence in 1965 in order to keep ruling over the African majority, the Latin American independence from Spain and Portugal in the 19th century had been to a large extent a way of consolidating the power of the privileged classes. The Declaration of Independence of Central America (1821), issued by the colonial political and religious authorities plus a handful of landowners and lawyers, says as much in its first article: 'Independence from the Spanish government being the general will of the people … Mr Political Chief should declare it in order to prevent the consequences which would be fearsome in the event that it were in fact proclaimed by the people themselves.'

Even more importantly, since 1947 all Latin American countries had been formally aligned with the United States as members of the Inter-Ameri-

can Treaty of Reciprocal Assistance (commonly known as the Rio Treaty) – a military alliance similar to NATO – and could not in any way be considered as 'neutral' in the Cold War that was at its peak in 1955. As part of the US-led bloc, all Latin American countries at that time had diplomatic relations with the government of Taipei and refused to recognise the People's Republic of China.

Hence the solitude of Latin America, looked down upon as underdeveloped and 'non-white' by Europe and the US, excluded by Africa and Asia for its subservience to the former.

Maybe it is no coincidence that the word 'solitude' appears in the titles of two of the best-known Latin American books outside the region: *The Labyrinth of Solitude* by Octavio Paz (published in 1950) and *One Hundred Years of Solitude* by Gabriel García Márquez (1967).

Octavio Paz points out that Mexicans (as well as many other Latin Americans) are symbolically the fruit of the rape of the 'Indian' (meaning indigenous) mother by the Spanish conquistador. They admire the powerful father but hate his violence towards a vulnerable mother whom they love but who makes them feel ashamed: 'The Mexican does not want to be either Indian or Spanish. Nor does he want to be descended from them. He denies them. And he does not affirm himself as a mixture, but rather as an abstraction: He is a man. He becomes the son of Nothingness.'

Tunisian writer Albert Memmi explored a similar psychology in his 1965 book *The Colonizer and the Colonized*, and the theme is also echoed in Martinique-born Frantz Fanon's first book *Black Skin, White Masks* (1952).

Historically, that foundational 'rape' was not a single isolated act, but the cultural and institutional result of three centuries of Spanish and Portuguese colonisation in the Americas, where the indigenous population was decimated by the brutality of forced labour and diseases such as smallpox from which they had no immunity. Millions of Africans were forcefully displaced to work in Latin America's plantations and mines.

Rebellions by the oppressed never ceased, however, and in 1804 victorious slaves established in Haiti the world's first black republic. By 1821 all of the continent was independent, but with the end of the Napoleonic wars in Europe the young republics feared the return of European monarchies.

Relations with world powers

In 1823 the US proclaimed the Monroe Doctrine stating that 'Europe should stay out of North and South America'. Latin Americans were however sceptical of this unilateral friendship. Since the US was not yet a world power and was itself fighting British attempts to recover its colonies (the White House was burned in 1812 by Canadian forces), many Latin American countries preferred to ally with Britain to keep Spain and Portugal away. The price to pay was to open up to free trade.

The Monroe Doctrine was reinterpreted in 1845 by US President James Polk to support his view of a 'manifest destiny'. Polk worried that France and Britain would insist on maintaining a balance of power in North America, but in fact, Britain peacefully surrendered its claim to the Oregon territory south of the 49th parallel in 1846 and no European power supported Mexico in the 1848 war in which it lost to the US the territories that are now Texas, California, Arizona, New Mexico, Nevada and Utah.

In 1862, when a French invasion imposed Maximilian of Austria as Mexican emperor, the US was involved in civil war and failed to apply the Monroe Doctrine and help its southern neighbour against the Europeans. Only in 1898 did the US actually invoke the doctrine against a European power, declaring war on Spain to side with Cuban independence fighters. As a result, the US ended up with the Philippines, Puerto Rico and Guam as bounty, as well as the Cuban base of Guantánamo and the 'right' to intervene at will in Cuba.

In 1902, Venezuelan harbours were bombed and invaded by the navies of Britain, Germany and Italy, which proceeded to occupy their customs in order to secure repayment of Venezuela's pending debt. Argentina protested and Foreign Minister Luis Maria Drago announced the doctrine (now known as the Drago Doctrine) that it is illegitimate to use force to claim payments on sovereign debt. US President Theodore Roosevelt rejected this as an extension of the Monroe Doctrine, declaring, 'We do not guarantee any state against punishment if it misconducts itself.'

Five Latin Americans participated in the First International Congress against Imperialism and Colonialism convened in 1927 in Brussels at the Palais d'Egmont. For them anti-imperialism meant resisting the aggressive US policy in Central America and the Caribbean, and the Congress passed a resolution in support of the struggle of General Sandino in Nicaragua against the invasion of US Marines.

Two years later, in 1929, the US stock market crash triggered the Great Depression. With American and European industry in crisis and subsequently diverted to war production, manufactures started to become scarce and expensive in Latin America and imports began to be substituted by local production. In a few years the region's economy bloomed and a new industrial bourgeoisie and working class emerged, protected and subsidised by the state. New political parties and leaders also came to the fore, such as Perón in Argentina, Getúlio Vargas in Brazil and Cárdenas in México, who nationalised oil and other natural resources, expanded universal education and promoted strong state-led trade unions.

Shortly after the end of the Second World War, the Truman Doctrine announced in April 1947 led to the start of the Cold War. Latin American countries were pushed to sign on to the Rio Treaty, a regional equivalent to NATO. All Latin American governments became signatories, including Mexico that had traditionally adopted

a foreign policy of neutrality. At the same time, however, a 'third path' movement rejecting alignment with either of the two blocs led by the US and the Soviet Union became popular among Latin Americans, gaining traction in the universities.

The early rejection of the Cold War was inspired by US political leader Henry Wallace, former vice-president of Franklin D Roosevelt and a campaigner for a global 'new deal', and French leaders Leon Blum (socialist) and Jacques Kayser (radical), who proposed a 'third bloc' with peace as the major concern.

Yet, by November 1947, Uruguayan journalist Carlos Quijano, who had been a delegate at the Brussels anti-colonial congress, concluded that 'Western Europe is unable to build a third force to establish some balance between Washington and Moscow' while 'Latin America has not managed to escape the gravitational force that pulls it to the US'. Not only had all countries of the continent signed the Rio Treaty of military cooperation with Washington but many of them were signing treaties of 'Friendship, Commerce and Economic Development' committing themselves to 'accord[ing] equitable treatment to the capital of nationals and companies of the other party'. This is the essence of what are now called 'investment agreements'.

Such 'equitable treatment' of American investments did not imply only that US-based companies should be allowed to operate in the countries and be properly compensated in case of expropriation. It also implied no performance requirements on their operations, such as the obligation to transfer technology, reinvest a percentage of profits or hire local expertise and buy local products. This constraint clearly limited the contribution of those transnational corporations to the development of the countries in which they operated.

Latin American prosperity started to fade in the early 1950s. European industry was rebuilt under the Marshall Plan and American industry, not damaged by the war but strengthened by war expenditures, was eager to reach markets abroad. Latin America's import-substitution policies and its corresponding nationalism became an obstacle. As anti-communism became an obsession in the US during the McCarthy era, all kinds of corrupt and cruel dictators all over Latin America were hailed as defenders of the 'free world'. That was the case with Anastasio Somoza, whose dynasty governed Nicaragua from 1930 until 1979, Rafael Trujillo in the Dominican Republic (1930-61) and Alfredo Stroessner in Paraguay (1954-89), among others.

In 1955 Brazilian President Getúlio Vargas, 'the father of the poor' who had started industrialisation with the steel furnaces of Volta Redonda and nationalised oil (Petrobras), was cornered by US-supported opposition and committed suicide in the presidential palace in Rio de Janeiro. In Argentina nationalist general Juan Perón was overthrown by a violent military coup, and in 1954 the democratically elected and reform-oriented government of Jacobo Arbenz in Guatemala was overthrown by a CIA-inspired coup that triggered three decades of violent repression against popular and indigenous movements.

Structural constraints to development

In such a scenario, the Colombo Group that organised the Bandung conference could not find anybody to invite in Latin America. It took six more years for one Latin American country – Cuba – to join the Non-Aligned Movement (NAM) in Belgrade (1961) and another decade for Chile and Peru to actively become members of NAM (at the 1973 Algiers summit).

The US reaction against Cuba and the latter's alignment with the Soviet Union was twofold. Firstly, the island was blockaded and expelled from the US-led regional body, the Organisation of American States headquartered in Washington. Secondly, an 'Alliance for Progress' was initiated by US President John Kennedy with the idea that bringing people out of poverty would deprive communism of its social roots.

Kennedy's Defence Secretary Robert McNamara, in his new job as President of the World Bank, announced in 1973 in a famous speech in Nairobi the expansion of that idea to the whole world: before 'the end of this century' extreme poverty, defined as an income of less than 30 cents a day, would be eradicated, by a combination of foreign aid and reforms at home, starting with agrarian reform.

That model never worked in Latin America because the elites never initiated genuine agrarian reform; aid was never significant; international rules were not conducive to channelling foreign investment to genuine development activities; and the terms of world trade were worsening.

From his position at the head of the UN Economic Commission for Latin America and the Caribbean (ECLAC), Argentinian economist Raúl Prebisch started to study the evolution of the terms of trade – the declining prices of commodities as opposed to those of manufactured products and capital goods – and, in general, how the global economy was structurally biased against 'periphery' countries. For development to work, trade needed to change.

Latin American countries rallied around this notion, pushed for the creation of the UN Conference on Trade and Development (UNCTAD) in 1964 and, in the process, were active in the creation of the Group of 77 (G77) as a negotiating group of developing countries in the UN concerned with economic issues (in parallel with NAM, which focused on peace and security issues).

Latin America was an active campaigner for the New International Economic Order in the early 1970s because the region felt that global changes were needed to overcome structural constraints to development. For a brief period it seemed that an alliance with a social democratic Western Europe, as expressed by the Independent Commission on International Development Issues led by Willy Brandt, could create that earlier envisioned 'third bloc'. But those

efforts were blockaded by the Reagan-Thatcher counter-revolution internationally and by the national security regimes at home.

A wave of right-wing military coups in Brazil (1964 and 1968), Chile and Uruguay (1973), Bolivia (1974), Peru (1974) and Argentina (1976) violently disbanded all communist, socialist and democratic parties, illegalised trade unions and massacred activists. Internationally, the national security regimes formed an axis with the apartheid regime in South Africa and the government of Taiwan, with active support from the Unification Church of South Korea's Reverend Moon and sectors of international organised crime.

But in contrast to the present-day European right-wing nationalists who abhor globalisation, the national security regimes embraced it. They privatised state enterprises and even social security, and opened up borders to trade and investment.

When democracy was gradually restored in Latin America in the late 1980s, the Soviet Union was collapsing, the US was proclaiming its victory in the Cold War and the most-heard phrases were 'the end of history' and 'TINA' (acronym for 'there is no alternative', the slogan of Margaret Thatcher). Economic liberalisation policies became part of the conditionalities imposed by the World Bank and the International Monetary Fund (IMF) for their loans to countries. Some countries, like Ecuador and El Salvador, even abolished their own currencies so as to guarantee investors that there would never be a state strong enough to regulate them.

In the 1990s nothing seemed to move in Latin America. Inequalities increased, and people lost faith in their leaders and started to demonstrate and demand a still undefined 'change'.

The first surprise came in Venezuela, where an obscure career military officer called Hugo Chávez won the elections in 1999 without any of the major political parties supporting him. He promised to lead the country towards '21st-century socialism' with a radical anti-imperialistic discourse.

cc Franklin Reyes

An adult literacy programme in Venezuela. Redistribution policies in Latin America in recent times are endorsed by the people who have voted progressive governments back in power.

In 2001 a group of non-governmental organisations, trade union leaders and environmental and social justice activists convened a meeting in Porto Alegre – the first major city of Brazil governed by the emerging Workers Party – under the slogan 'Another world is possible,' the exact opposite of TINA. That first World Social Forum was scheduled to coincide with – and be the counterpoint to – the annual World Economic Forum which brought the global business and political elites together in Davos, Switzerland. Three thousand people were expected at the WSF. Twenty thousand showed up.

A few months later Luiz Inacio da Silva, popularly known as Lula, was elected President of Brazil. A new wave of popular, reform-oriented leaders took over South America. Their life stories captured the imagination of the public: Lula was born into a family of poor migrants fleeing the drought of the Northeast for Sao Paulo, where he did shoe-shining before becoming a metal worker and then union leader. Bolivia's Evo Morales was born to an indigenous family and led a peasants organisation. Michelle Bachelet is the daughter of a Chilean general killed by the dictator Pinochet and she and her mother suffered imprisonment and torture, the same as José Mujica from Uruguay and Dilma Rousseff (Lula's successor) from Brazil.

The personal lives of the highest political figures dramatically illustrate how the victims of four decades ago are now at the top. But what does that change for the people?

The change is enormous. Former human rights violators have been tried and jailed, and rights are not only respected but have been expanded to include, in some cases, the right of women to decide over their bodies, everybody's right to marry the person of their choice, the right to social security and the right to free education. Inequalities have decreased, thanks to the expansion of social programmes. Taxation policies are being made more progressive and the state has recovered a role in the economy. Indebtedness has been reduced and, with it, dependence on IMF conditionalities.

A year ago I organised a debate between the Uruguayan government and civil society activists from around the world. We heard from the ministers who led the process how, after the financial crisis of 2002 that impoverished the population, the policies they applied were the opposite of what the World Bank and the IMF were recommending. The minimum wage was increased, trade unions were strengthened, collective bargaining was made mandatory and social security was

expanded. As a result, a virtuous circle was created, unemployment was reduced to a historic low and foreign investment, instead of leaving the country, increased. This is the opposite of the austerity policies that are the recipe for a similar crisis now raging in Europe and in many developing countries.

The success of Latin American redistribution policies is not yet recognised by mainstream economists, but is endorsed by the peoples that have voted these governments back in power. Never before in history has the region had such a long period without coups d'etat and with functioning democratic institutions.

But this 'first generation' of reforms has not yet changed basic structures of land ownership or the patterns of production. Latin America is still largely an exporter of commodities and importer of manufactures. In spite of all the changes so far, levels of income inequality, crime and social violence are still the highest in the world. The region also needs and hopes for global rules to change so that its domestic efforts find an enabling international environment.

Thus, in 2014 Argentina spearheaded efforts that led to the UN General Assembly launching a process to establish a fair workout mechanism for sovereign debts (something that UNCTAD has been demanding for decades), while Ecuador initiated a similar process at the UN Human Rights Council to agree on binding rules for transnational corporations to respect human rights. These moves have been motivated by their respective experiences: Argentina is being attacked by 'vulture funds' which oppose restructuring of the country's debt, and Ecuador has been fighting for 30 years against major oil companies to remedy the damage they wrought upon the Amazon jungle and its peoples. Both resolutions at the UN were passed with support from the G77 and China and a handful of other countries, despite the partial abstention of Europe and the negative vote of the US and its close allies.

In international politics the ministerial meeting of the World Trade Organisation (WTO) in Cancun in 2003 provided for the first time dramatic evidence of a new Latin American role. Led by Lula, the Latin American members of the Cairns Group of agriculture exporters (a mix of countries that included Latin American and Asian agriculture exporters in alliance with Australia and New Zealand) that promoted further liberalisation of farm trade, decided to form a new alliance of developing countries that was named the G20 (no relation to the G20 major economies grouping) to defend notions of food sovereignty. Brazil and India started to coordinate their positions at the WTO and that changed the whole balance of forces. The Cancun meeting 'collapsed' but developing countries celebrated that result because 'no deal is better than a bad deal'.

Two years later, in Mar del Plata (2005) Latin American countries rejected the proposal of US President George W Bush to establish a Free Trade Area of the Americas because they perceived further liberalisation as running contrary to their interests. Instead, in 2008 the Union of South American Nations (UNASUR) was created, and the Community of Latin American and Caribbean States (CELAC) came into being in 2010.

The launch of the Banco del Sur (Bank of the South) to pool regional funds to finance development and the moves towards promoting intra-regional trade and financial collaboration are the major results of those regional efforts.

CELAC met in January 2015 in Costa Rica and agreed on a comprehensive action plan that includes the consolidation of a CELAC-China Forum and the organisation in 2015 of a CELAC-India Forum and a CELAC-Russia Forum. That is a major contrast with the Summit of the Americas in April 2015 in Panama attended by those same countries plus the US and Canada. The handshake between Cuban President Raúl Castro and Barack Obama was the only noteworthy outcome of that meeting. It was welcomed as it signified the end of 50 years of hostility towards Cuba by the US, something that Latin America had been requesting for many years. But no common communiqué emerged from the summit, which shows how enormous the gap is between the aspirations of the US and its southern neighbours.

Some signals coming from Latin America in recent weeks are worrisome though. The dramatic drop in oil prices has created economic difficulties in Venezuela, where political polarisation between the government and the opposition is intensifying; corruption scandals in Petrobras are tarnishing the image of the Workers Party in Brazil; and Argentina is entering a turbulent electoral period in the midst of economic uncertainties. Falling commodity prices are having an impact everywhere. Does this then mark the end of a cycle?

I cannot predict the future and can only turn once again to one of our great writers. The final paragraph of *One Hundred Years of Solitude* reads:

'Before reaching the final line, however, he had already understood that he would never leave that room, for it was foreseen that the city of mirrors (or mirages) would be wiped out by the wind and exiled from the memory of men at the precise moment when Aureliano Babilonia would finish deciphering the parchments, and that everything written on them was unrepeatable since time immemorial and forever more, because races condemned to one hundred years of solitude did not have a second opportunity on earth.'

That is the end of the book and of its fictional town of Macondo, which many see as a metaphor for Latin America. Is this tragic end a destiny or a warning? I believe that our fate as Latin Americans is not written in any parchment and therefore cannot be read. The solitude of Latin America will not last one hundred years and the way to avoid repeating the curse of the past is to reach out to Africa and Asia and together build the future. ◆

Roberto Bissio is Executive Director of the Third World Institute (ITeM) and coordinator of Social Watch. This article is based on a speech delivered at the Bandung – Third World 60 Years forum held in Hangzhou, China, on 17-19 April 2015.

Saudi Arabia's attack on Yemen: Conquest or quagmire?

In addition to causing a humanitarian disaster, Saudi Arabia's aerial bombardment of Yemen threatens to destabilise the country and provoke a sectarian conflict, says *Rannie Amiri*.

Jet fighters from the Saudi air force. Saudi Arabia launched a massive aerial bombing campaign in Yemen in March.

THE Saudi regime is notoriously adept at funding wars, but exceptionally poor at fighting them.

On 25 March, a massive aerial bombing campaign began against Zaidi Houthi rebels who had recently assumed control of Yemen's capital and forced its US- and Saudi-backed president, Abd Rabbuh Mansour Hadi, to flee first to the southern port city of Aden and then to Riyadh.

This is the second Saudi attack on Yemen – the Arab world's poorest country bordering one of its richest – in less than six years. 'Operation Scorched Earth' was launched by the Yemeni government against the Houthis in August 2009. In November of that year, Saudi troops amassed on the border and began shelling Saada governorate in northwest Yemen where the rebels were based.

The Saudi offensive created tens of thousands of internally displaced civilians, teeming refugee camps and rampant malnutrition. The Houthis, in the face of overwhelming firepower and far worse off then than today, nevertheless kept Saudi troops at bay and inflicted higher-than-expected causalities on their forces. Six years later and with nearly all Arab countries aligned against them, they are doing so again.

Background

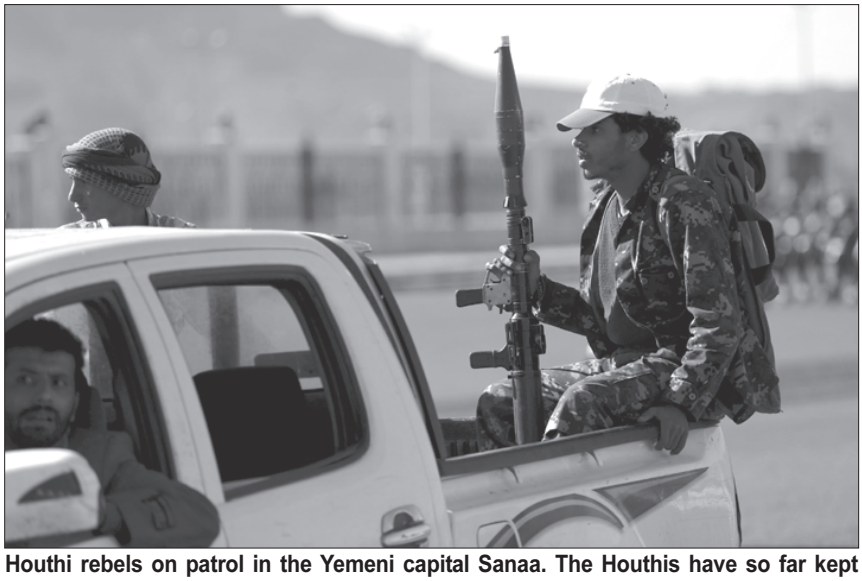
To put Yemen's current predicament in context, some background history is helpful.

The Zaidi Shia form at least a quarter of Yemen's population and are concentrated in the north of the country. This area was once ruled by Hashimite Zaidis (those descended from the line of the Prophet Muhammad) for more than 1,000 years until they were overthrown in 1962 by an alliance of nationalist military officers who then founded the Yemen Arab Republic. Zaidi Muslims are nominally categorised as Shia Muslims although they are actually closer to the Sunni schools of jurisprudence.

The rebels were first led by Zaidi cleric Hussein Badr al-Din al-Houthi – from whom the Houthis derive their name – and his Shabab al-Momineen group who fought the government of President Ali Abdullah Saleh. Their dispute dates to June 2004 when Saleh, the Saudi-backed strongman, charged the Houthis with sedition and claimed their true aim was to revive Zaidi Shia Imamate rule deposed four decades earlier. For their part, the Houthis sought to reverse the systemic political and socioeconomic marginalisation their community faced as well as stem the rise of Salafi/Wahabi ideology and the al-Qaeda presence it fostered, both of which had gained an increasing foothold in the country.

Hussein al-Houthi was killed by the army in September 2004 and his brother, Abdul Malik, assumed leadership. He now leads the Houthi movement under the group Ansarullah. Worried that the Houthis could transform into a Hezbollah-like organisation, the Saudis attacked in 2009. Then, as now, this was done with US-supplied advanced weaponry including surface-to-air missiles, Apache attack helicopters and Phantom jet fighters. Despite their sophisticated arms, Saudi Arabia lost an unusually high number of soldiers in the campaign.

The Houthis persevered; their resilience and desire for equitable representation in government led Saudi Arabia and a coalition of Gulf Cooperation Council (GCC) countries



Houthi rebels on patrol in the Yemeni capital Sanaa. The Houthis have so far kept Saudi forces at bay in the face of overwhelming firepower.

(with the exception of Oman) to attack in March of this year when 'Operation Decisive Storm' began. Predictably, its pretext was the tired canard of curbing Iranian influence in the Arabian Peninsula. Direct, material support for the Houthis by Iran has never been clearly demonstrated however.

The real motive for the assault and the process it intended to disrupt was revealed by former UN envoy Jamal Benomar in an April interview with the *Wall Street Journal*. Benomar remarks, 'When this campaign started, one thing that was significant but went unnoticed is that the Yemenis were close to a deal that would institute power-sharing with all sides, including the Houthis.'

Humanitarian toll

The Saudi offensive, led by the young defence minister and newly appointed deputy crown prince, Muhammad bin Salman, has again exacted a tremendous humanitarian toll: 1,200 killed and more than a quarter of a million people displaced. In 2009, the Saudis were accused of using white phosphorus (as the Israelis had been in their wars on Gaza). Today, they are charged with using cluster bombs (as the Israelis had been in their wars on Lebanon). Human Rights Watch said in a statement, 'Credible evidence indicates that the Saudi-led coalition used banned cluster munitions supplied by the United States in air strikes against the Houthi forces.'

Even after all tools of war were placed at their disposal by the West, the House of Saud still pleaded with Pakistan to send (Sunni-only) troops to fight for them. The regime has blockaded the port at Aden and has even resorted to bombing Sanaa's airport to prevent the delivery of needed relief supplies.

All of these measures have failed to halt the Houthi advance.

Only a political solution will end Yemen's bloodshed. The GCC though prefers to frame the conflict as an existential one pitting Arabs against Iranians, Sunnis versus Shias. This serves to stoke the sectarian flames already engulfing the region and makes a practical resolution near impossible.

The war has been a disaster for the Yemeni people from the start, both politically and on the most basic humanitarian level. Al-Qaeda now has the potential to flourish as Yemenis are pitted against one another based on sect; the possibility of a just compromise and representative government without Saudi Arabia's hand-picked man at the helm is well forestalled.

Will the Saudi regime find themselves in a military quagmire? The Houthis show no sign of withering under relentless bombing. Or is a decisive ground invasion in the works? There are early signs this may yet occur. But as in Iraq and Syria, the monarchy appears content with the status quo, ensuring chaos, instability and sectarianism prevail. ◆

The Saudi offensive in Yemen has exacted a tremendous humanitarian toll. Picture shows people carrying the body of a child at the site of a Saudi airstrike in Sanaa.

Rannie Amiri is an independent commentator on Middle East affairs. This article is reproduced from CounterPunch.org.

The media misses the point on 'proxy war'

Yemen is a Saudi war of aggression, while Syria and Libya are the result of a dangerous Gulf-led strategy of backing groups of sectarian fighters.

US soldiers in Iraq, 2007. The US and its NATO allies 'opened the floodgates for regional proxy wars with the two major wars for regime change in Iraq and Libya.'

Gareth Porter

THE term 'proxy war' has experienced a new popularity in stories on the Middle East. Various news sources began using the term to describe the conflict in Yemen immediately, as if on cue, after Saudi Arabia launched its bombing campaign against Houthi targets in Yemen on 25 March. 'The Yemen Conflict Devolves into Proxy War,' the *Wall Street Journal* headlined the following day. 'Who's fighting whom in Yemen's proxy war?' a blogger for Reuters asked on 27 March.

And on the same day the *Journal* pronounced Yemen a proxy war, NBC News declared that the entire Middle East was now engulfed in a proxy war between Iran and Saudi Arabia.

It is certainly time to discuss the problem of proxy war in the Middle East, because a series of such wars are at the heart of the destabilisation and chaos engulfing the region. The problem with the recent stories featuring the term is that it is being used in a way that obscures some basic realities that some news media are apparently not comfortable acknowledging.

The real problem of proxy war must begin with the fact that the United States and its NATO allies opened the floodgates for regional proxy wars with the two major wars for regime change in Iraq and Libya. Those two profoundly destabilising wars provided obvious opportunities and motives for Sunni states across the Middle East to pursue their own sectarian and political power objectives through proxy war.

Is Yemen really a proxy war?

Prominent 20th-century political scientist Karl Deutsch defined 'proxy war' as 'an international conflict between two foreign powers, fought out on the soil of a third country, disguised as a conflict over an internal issue of the country and using some of that country's manpower, resources and territory as a means of achieving preponderantly foreign goals and foreign strategies'.

Deutsch's definition makes it clear that proxy war involves the use of another country's fighters rather than the direct use of force by the foreign power or powers. So it is obvious that the Saudi bombing in Yemen, which has killed mostly civilians and used cluster bombs that have been outlawed by much of the world, is no proxy war but a straightforward external military aggression.

The fact that the news media began labelling Yemen a proxy war in response to the Saudi bombing strongly suggests that the term was a way of softening the harsh reality of Saudi aggression.

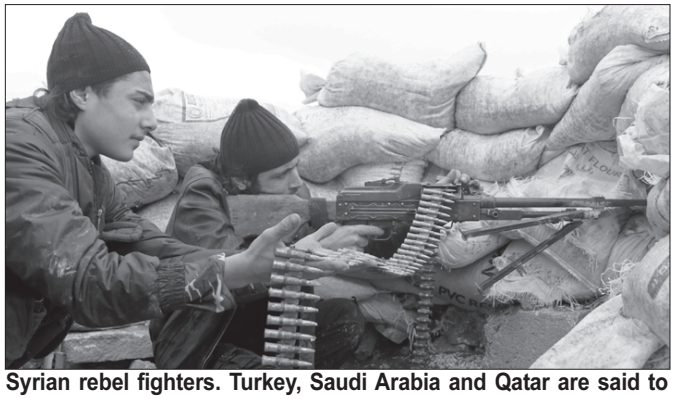
The assumption underlying that application of 'proxy war' is, of course, that Iran had already turned Yemen into such a war by its support for the Houthis. But it ignores the crucial question of whether the Houthis had been carrying out 'preponderantly foreign goals and foreign strategies'. Although Iran has certainly had ties with the Houthis, the Saudi propaganda line that the Houthis have long been Iranian proxies is not supported by the evidence.

Far from proving the Iranian proxy argument, the Houthi takeover of Sanaa last year has actually provided definitive evidence to the contrary. US intelligence sources recently told the Huffington Post that before the Houthis entered the capital, the Iranians had advised against such a move, but that the Houthis ignored that advice. Gabriele vom Bruck, a leading academic specialist on Yemen at the School of Oriental and African Studies, said in an e-mail to this writer

that senior Yemeni officials with links to intelligence had told her the same thing weeks before the story was leaked.

The Houthis rejected the Iranian caution, vom Bruck believes, because former President Ali Abdullah Saleh and his son Ahmed Ali Saleh (the former commander of the Republican Guard) had indicated to them that troops that were still loyal to them would not resist the Houthi units advancing on the capital unless the Houthis attacked them.

So the Houthis clearly don't intend to serve an Iranian strategy for Yemen. 'Certainly the Houthis do not want to replace the Saudis with the Iranians,' says vom Bruck, even though they still employ slogans borrowed from Iran.



Syrian rebel fighters. Turkey, Saudi Arabia and Qatar are said to have competed with one another to create proxy forces with which to overthrow the Assad regime in Syria.

Regional proxy war?

The NBC story on a 'regional proxy war' completely misses the seriousness of the problem. It turns its proxy war concept into an abstract and virtually antiseptic problem of limiting Iranian influence in the region through the US bombing Iraq. It ignores the fact that the regional actors behind the wars in Syria, Iraq and Libya are pulling the region into a new era of unbridled sectarian violence and instability.

The crimes committed by the Syrian regime in the war are unconscionable, but the policies of external countries pursuing a proxy war to overthrow the existing regime have created a far more ominous threat to the entire region. *Washington Post* columnist David Ignatius has detailed the process by which Turkey, Saudi Arabia and Qatar competed with one another to create proxy forces with which to overthrow the Assad regime.

Such unbridled competition in the creation of armies for regime change was by its very essence a reckless and cynical use of power that carried the obvious risk of even worse chaos and violence of the war in Syria. But they have made the costs of proxy war far greater by targeting the most aggressive armed groups they could find as their clients, and their weapons soon 'made their way to the terrorist groups', wrote Ignatius, to which the Turks and Qataris 'turned a blind eye'.

Once it became clear that Sunni states were creating a proxy war in Syria that could tip the balance against the Syrian regime, Iran and Hezbollah intervened in support of the regime.

But what the conventional view of the Syrian proxy war leaves out is the linkage between Syria and Iran's deterrence strategy. Iran is militarily weak in relation to Israel and US military power in the Middle East, and has been the target of US and Israeli military threats going back to the 1990s. Iran's deterrent to such attacks has depended on the threat of retaliatory rocket attacks against Israel by Hezbollah from Southern Lebanon – destroying the ability of Hezbollah to retaliate for an attack was the single biggest reason for Israel's 2006 war against Hezbollah.

The Assad regime was part of the Iranian deterrent as well. Not only did Syria have a force of several hundred missiles that Israel would have to take into account, but Syrian territory is also the shortest route for Iranian resupply of Hezbollah.

The Saudi fixation with bringing down the Iraqi Shia regime appears to reflect the sentiment that Prince Bandar bin Sultan expressed to Richard Dearlove, then head of British intelligence agency MI6, before 9/11. 'The time is not far off in the Middle East, Richard,' said Bandar, 'when it will be literally "God help the Shia". More than a billion Sunnis have simply had enough of them.'

The Saudis have never been reconciled to the establishment of a Shia regime in Iraq since the United States occupied the country and set up a Shia-dominated regime. They began facilitating the dispatch of Sunni extremists to Iraq to overthrow the Shia regime early in the US war. After the US withdrawal from Iraq, the funding from the Saudis and other Gulf sheikdoms for Sunni fighters in Iraq and arms moved towards the best organised forces, which ultimately meant ISIS.

The NATO war for regime change in Libya, like the US occupation of Iraq, opened a path for the regional proxy war that followed. That war took the form of competitive intervention by regional actors leading to worsening violence. This time Qatar and the UAE were competing for power through their support for Libyan expatriates in their own countries.

The Qataris steered their support to the Libyan Islamic Fighting Group, which the US State Department had identified as a terrorist organisation as early as 2004. The Sisi regime in Egypt joined the proxy war as the chief sponsor of counter-terrorism. The UAE aligned with that position, while Qatar remained in opposition. The regional proxy war has led to a longer-term structure of conflict.

The media stories have offered only anodyne references to the problem of proxy war. What is needed in media coverage is a focus on the nasty realities of proxy war and their origins. ◆

Gareth Porter is an independent investigative journalist and winner of the 2012 Gellhorn Prize for journalism. He is the author of the newly published Manufactured Crisis: The Untold Story of the Iran Nuclear Scare. *The above article is reproduced from the Middle East Eye website (www.middleeasteye.net).*

The secret country again wages war on its own people

Despite warnings from Aboriginal leaders about 'a new generation of displaced people' and 'cultural genocide', Australia's ruling elite has intensified its assault on the rights of the country's Indigenous people. *John Pilger* explains.

AUSTRALIA has again declared war on its Indigenous people, reminiscent of the brutality that brought universal condemnation on apartheid South Africa. Aboriginal people are to be driven from homelands where their communities have lived for thousands of years. In Western Australia, where mining companies make billion-dollar profits exploiting Aboriginal land, the state government says it can no longer afford to 'support' the homelands.

Vulnerable populations, already denied the basic services most Australians take for granted, are on notice of dispossession without consultation, and eviction at gunpoint. Yet again, Aboriginal leaders have warned of 'a new generation of displaced people' and 'cultural genocide'.

'Genocide' is a word Australians hate to hear. Genocide happens in other countries, not the 'lucky' society that per capita is the second richest on earth. When 'act of genocide' was used in the 1997 landmark report 'Bringing Them Home', which revealed that thousands of Indigenous children had been stolen from their communities by white institutions and systematically abused, a campaign of denial was launched by a far-right clique around the then prime minister John Howard. It included those who called themselves the Galatians Group, then Quadrant, then the Bennelong Society; the Murdoch press was their voice.

The Stolen Generation was exaggerated, they said, if it had happened at all. Colonial Australia was a benign place; there were no massacres. The First Australians were victims of their own cultural inferiority, or they were noble savages. Suitable euphemisms were deployed.

Australia's Aboriginal people are set to be driven from homelands where their communities have lived for thousands of years.

Governmental assault

The government of the current prime minister, Tony Abbott, a conservative zealot, has revived this assault on a people who represent Australia's singular uniqueness. Soon after coming to office, Abbott's government cut $534 million in Indigenous social programmes, including $160 million from the Indigenous health budget and $13.4 million from Indigenous legal aid.

In the 2014 report 'Overcoming Indigenous Disadvantage: Key Indicators', the devastation is clear. The number of Aboriginal people hospitalised for self-harm has leapt, as have suicides among those as young as 11. The indicators show a people impoverished, traumatised and abandoned. Read the classic expose of apartheid South Africa, *The Discarded People* by Cosmas Desmond, who told me he could write a similar account of Australia.

Having insulted Indigenous Australians by declaring (at a G20 breakfast for British premier David Cameron) that there was 'nothing but bush' before the white man, Abbott announced that his government would no longer honour the longstanding commitment to Aboriginal homelands. He sneered, 'It's not the job of the taxpayers to subsidise lifestyle choices.'

The weapon used by Abbott and his redneck state and territorial counterparts is dispossession by abuse and propaganda, coercion and blackmail, such as his demand for a 99-year leasehold of Indigenous land in the Northern Territory in return for basic

services: a land grab in all but name. The Minister for Indigenous Affairs, Nigel Scullion, refutes this, claiming 'this is about communities and what communities want'. In fact, there has been no real consultation, only the co-option of a few.

Both conservative and Labor governments have already withdrawn the national jobs programme, CDEP, from the homelands, ending opportunities for employment, and prohibited investment in infrastructure: housing, generators, sanitation. The saving is peanuts.

The reason is an extreme doctrine that evokes the punitive campaigns of the early 20th century 'chief protector of Aborigines', such as the fanatic A.O. Neville who decreed that the First Australians 'assimilate' to extinction. Influenced by the same eugenics movement that inspired the Nazis, Queensland's 'protection acts' were a model for South African apartheid. Today, the same dogma and racism are threaded through anthropology, politics, the bureaucracy and the media. 'We are civilised, they are not,' wrote the acclaimed Australian historian Russel Ward two generations ago. The spirit is unchanged.

Having reported on Aboriginal communities since the 1960s, I have watched a seasonal routine whereby the Australian elite interrupts its 'normal' mistreatment and neglect of the people of the First Nations, and attacks them outright. This happens when an election approaches, or a prime minister's ratings are low. Kicking the blackfella is deemed popular, although grabbing mineral-rich land by stealth serves a more prosaic purpose. Driving people into the fringe slums of 'economic hub towns' satisfies the social engineering urges of racists.

The last frontal attack was in 2007 when Prime Minister Howard sent the army into Aboriginal communities in the Northern Territory to 'rescue children' who, said his Minister for Aboriginal Affairs, Mal Brough, were being abused by paedophile gangs in 'unthinkable numbers'.

The media played a vital role in what was known as 'the intervention'. In 2006, the national TV current affairs programme, the Australian Broadcasting Corporation (ABC)'s *Lateline*, broadcast a sensational interview with a man whose face was concealed. Described as a 'youth worker' who had lived in the Aboriginal community of Mutitjulu, he made a series of lurid allegations. Subsequently exposed as a senior government official who reported directly to the minister, his claims were discredited by the Australian Crime Commission, the Northern Territory Police and a damning report by child medical specialists. The community received no apology.

The 2007 'intervention' allowed the federal government to destroy many of the vestiges of self-determination in the Northern Territory, the only part of Australia where Aboriginal people had won federally legislated land rights. Here, they had administered their homelands with the dignity of self-determination and connection to land and culture and, as Amnesty reported, a 40% lower mortality rate.

It is this 'traditional life' that is anathema to a parasitic white industry of civil servants, contractors, lawyers and consultants that controls and often profits from Aboriginal Australia, if indirectly through the corporate structures imposed on Indigenous organisations. The homelands are seen as a threat, for they express a communalism at odds with the neoconservatism that rules Australia. It is as if the enduring existence of a people who have survived and resisted more than two colonial centuries of massacre and theft remains a spectre on white Australia: a reminder of whose land this really is.

Political attack

The current political attack was launched in the richest state, Western Australia. Last October, the state premier, Colin Barnett, announced that his government could not afford the $90 million budget for basic municipal services to 282 homelands: water, power, sanitation, schools, road maintenance, rubbish collection. It was the equivalent of informing the white suburbs of Perth that their lawn sprinklers would no longer sprinkle and their toilets no longer flush; and they had to move; and if they refused, the police would evict them.

Where would the dispossessed go? Where would they live? In six years, Barnett's government has built few houses for Indigenous people in remote areas. In the Kimberley region, Indigenous homelessness – aside from natural disaster and civil strife – is one of the highest anywhere, in a state renowned for its conspicuous wealth, golf courses and prisons overflowing with impoverished black people. Western Australia jails Aboriginal males at more than eight times the rate of apartheid South Africa. It has one of the highest incarceration rates of juveniles in the world, almost all of them Indigenous, including children kept in solitary confinement in adult prisons, with their mothers keeping vigil outside. In 2013, the former prisons minister, Margaret Quirk, told me that the state was 'racking and stacking' Aboriginal prisoners. When I asked what she meant, she said, 'It's warehousing.'

In March, Barnett changed his story. There was 'emerging evidence', he said, 'of appalling mistreatment of little kids' in the homelands. What evidence? Barnett claimed that gonorrhoea had been found in children younger than 14, then conceded he did not know if these were in the homelands. His police commissioner, Karl O'Callaghan, chimed in that child sexual abuse was 'rife'. He quoted a 15-year-old study by the Australian Institute of Family Studies. What he failed to say was that the report highlighted poverty as the overwhelming cause of 'neglect' and that sexual abuse accounted for less than 10%.

The Australian Institute of Health and Welfare, a federal agency, recently released a report on what it calls the 'Fatal Burden' of Third World disease and trauma borne by Indigenous people 'resulting in almost 100,000 years of life lost due to premature death'. This 'fatal burden' is the product of extreme poverty imposed in Western Australia, as in the rest of

Australia, by the denial of human rights.

In Barnett's vast, rich Western Australia, barely a fraction of mining, oil and gas revenue has benefited communities to which his government has a duty of care. In the town of Roeburne in the midst of the booming mineral-rich Pilbara, 80% of the Indigenous children suffer from an ear infection called otitis media that causes deafness.

In 2011, the Barnett government displayed a brutality in the community of Oombulgurri the other homelands can expect. 'First, the government closed the services,' wrote Tammy Solonec of Amnesty International. 'It closed the shop, so people could not buy food and essentials. It closed the clinic, so the sick and the elderly had to move, and the school, so families with children had to leave, or face having their children taken away from them. The police station was the last service to close, then eventually the electricity and water were turned off. Finally, the ten residents who resolutely stayed to the end were forcibly evicted [leaving behind] personal possessions. [Then] the bulldozers rolled into Oombulgurri. The WA government has literally dug a hole and in it buried the rubble of people's homes and personal belongings.'

In South Australia, the state and federal governments launched a similar attack on the 60 remote Indigenous communities. South Australia has a long-established Aboriginal Lands Trust, so people were able to defend their rights – up to a point. On 12 April, the federal government offered $15 million over five years. That such a miserly sum is considered enough to fund proper services in the great expanse of the state's homelands is a measure of the value placed on Indigenous lives by white politicians who unhesitatingly spend $28 billion annually on armaments and the military. Haydn Bromley, chair of the Aboriginal Lands Trust, told me, 'The $15 million doesn't include most of the homelands, and it will only cover bare essentials – power, water. Community development? Infrastructure? Forget it.'

The 'great Australian silence'

The current distraction from these national dirty secrets is the 'celebrations' of the centenary of an Edwardian military disaster at Gallipoli in 1915 when 8,709 Australian and 2,779 New Zealand troops – the Anzacs – were sent to their death in a futile assault on a beach in Turkey. In recent years, governments in Canberra have promoted this imperial waste of life as an historical deity to mask the militarism that underpins Australia's role as America's 'deputy sheriff' in the Pacific.

In bookshops, 'Australian non-fiction' shelves are full of opportunistic tomes about wartime derring-do, heroes and jingoism. Suddenly, Aboriginal people who fought for the white man are fashionable, whereas those who fought against the white man in defence of their own country, Australia, are unfashionable. Indeed, they are officially non-people. The Australian War Memorial refuses to recognise their remarkable resistance to the British invasion. In a country littered with Anzac memorials, not one official memorial stands for the thousands of native Australians who fought and fell defending their homeland.

This is part of the 'great Australian silence', as W E H Stanner in 1968 called his lecture in which he described a 'cult of forgetfulness on a national scale'. He was referring to the Indigenous people. Today, the silence is ubiquitous. In Sydney, the Art Gallery of New South Wales currently has an exhibition, 'The Photograph and Australia', in which the timeline of this ancient country begins, incredibly, with Captain Cook.

The same silence covers another enduring, epic resistance. Extraordinary demonstrations of Indigenous women protesting the removal of their children and grandchildren by the state, some of them at gunpoint, are ignored by journalists and patronised by politicians. More Indigenous children are being wrenched from their homes and communities today than during the worst years of the Stolen Generation. A record 15,000 are presently detained 'in care'; many are given to white families and will never return to their communities.

Last year, the West Australian Police Minister, Liza Harvey, attended a screening in Perth of my film *Utopia*, which documented the racism and thuggery of police towards black Australians and the multiple deaths of young Aboriginal men in custody. The minister cried.

On her watch, 50 City of Perth armed police raided an Indigenous homeless camp at Matagarup, and drove off mostly elderly women and young mothers with children. The people in the camp described themselves as 'refugees ... seeking safety in our own country'. They called for the help of the United Nations High Commissioner for Refugees.

Australian politicians are nervous of the United Nations. Abbott's response has been abuse. When Professor James Anaya, the UN Special Rapporteur on Indigenous People, described the racism of the 'intervention', Abbott told him to 'get a life' and 'not listen to the old victim brigade'.

The planned closure of Indigenous homelands breaches Article 5 of the International Convention for the Elimination of Racial Discrimination (ICERD) and the UN Declaration on the Rights of Indigenous Peoples (UNDRIP). Australia is committed to 'provide effective mechanisms for prevention of, and redress for ... any action which has the aim of dispossessing [Indigenous people] of their lands, territories or resources'. The International Covenant on Economic, Social and Cultural Rights is blunt. 'Forced evictions' are against the law.

International momentum is building. In 2013, Pope Francis urged the world to act against racism and on behalf of 'indigenous people who are increasingly isolated and abandoned'. It was South Africa's defiance of such a basic principle of human rights that ignited the international opprobrium and campaign that brought down apartheid. Australia beware. ◆

John Pilger is an Australian-born journalist, author and filmmaker. This article is reproduced from his website JohnPilger.com.

The biggest lessons Nepal will take away from this tragedy

Nepal has been struck by two earthquakes over a space of three weeks and as a result, more than 8,500 people have died. While it is clear that the country will require massive external aid for years to come, in the following piece written soon after the first quake, *Amantha Perera* points out that there is also a need for the country to build a stronger national preparedness policy and mechanism to better cope with future catastrophes.

THERE has never been any doubt that Nepal is sitting on one of the most seismically active areas in South Asia. The fact that, when the big one struck, damages and deaths would be catastrophic has been known for years.

Indeed, when this correspondent visited Nepal several years ago, and found himself climbing up the narrow, winding stairwell of the Nepal Red Cross Society office in Kathmandu, a poster on one of the doors demanded a close read: 'Kathmandu Valley is most vulnerable during an earthquake.'

An estimated eight million people, representing over a quarter of the population, have been affected by the earthquake disaster in Nepal.

'One study has shown that in case of an earthquake, 40,000 people may die, 95,000 persons may be seriously injured and 60 percent of houses will be totally destroyed.'

Looking out of the window at the densely populated hillsides, dotted with three-storey concrete structures hugging each other in the jam-packed metropolis, it was clear the warnings were not hyperbolic.

Little over a month before the massive earthquake struck on 25 April, Mahendra Bahadur Pandey, Nepal's minister for foreign affairs, warned the world yet again of what was to come. 'It is ... estimated that the human losses in the Kathmandu Valley alone, should there be a major seismic event, will be catastrophic,' he told the United Nations World Conference on Disaster Risk Reduction in Sendai, Japan, in March.

Horrifyingly, his words were prophetic of the tragedy that unfolded not long after.

Caught off-guard

Less than two weeks after the 7.8-magnitude quake rippled through Nepal, close to 8,000 people have been pronounced dead, while hundreds are still missing. Families wait for news, while officials wait for their worst fears to be confirmed: that the death toll will likely climb higher in the coming days.

Over 17,500 people are injured, and 10 hospitals have been completely destroyed, according to the United Nations Office for the Coordination of Humanitarian Affairs (OCHA).

An estimated eight million people, largely in the country's Western and Central Regions, have been affected by the disaster – representing over a quarter of Nepal's population of over 27 million people.

The largest cities, such as Kathmandu and Pokhara, have been badly hit; within 72 hours of the quake, over half a million fled Kathmandu to outlying areas.

Despite ample evidence of the damage a disaster of this scale could wreak on the country, Nepal was in many ways caught unawares, and is now struggling to meet the challenges of providing for a beleaguered and petrified population, who weathered numerous aftershocks in the week following the major quake.

Scores of families are still living in tents, while the World Health Organisation (WHO) has issued an urgent funding appeal for the estimated 3.5 million people in need of emergency food aid.

With so many hospitals destroyed, doctors have resorted to treating patients in the street. The UN health agency has allocated $1.1 mil-

lion for medical staff and supplies and has so far treated 50,000 patients in the 14 most severely affected districts.

'Resources woefully lacking'

But there is a limit to what aid agencies and donor countries can do, and eventually the government will have to shoulder the lion's share of the recovery effort: something experts feel Nepal is unprepared for.

'It is a massive relief operation, probably the largest in this region that we have launched,' Orla Fagan, regional media officer at OCHA's office in Bangkok, Thailand, told Inter Press Service (IPS).

The long-term reconstruction bill could be as high as $5 billion, while UN agencies have said they need at least $415 million for more immediate efforts over the next three months.

Fagan said that because the threat levels were known, some degree of coordination and disaster preparedness work was being carried out in the Himalayan country prior to the disaster, mostly relating to training and building awareness.

'There was coordination between the government and UN agencies, but it was on a very small scale,' she said.

'You need to understand that this is one of the poorest countries in the world and resources were woefully lacking,' she added.

Nepal is considered a least developed country (LDC) and currently ranks 145 out of 187 on the United Nations Human Development Index (HDI).

It is also saddled with massive debt – over $3.8 billion owed to donors like the World Bank, the International Monetary Fund (IMF) and the Asian Development Bank (ADB) – and funnelled over $217 million into debt repayments last year, money that might have been better spent shoring up its disaster preparation and management systems.

Fagan explained that the main gaps in disaster preparedness levels were in information management, with the government failing to collect data gathered by various actors into a cohesive national data bank.

The country was also lacking a tried-and-tested national blueprint on early response and coordination of relief efforts.

A little-known fact is that despite the very real threats of earthquakes, heavy rains, landslides and glacial lake outbursts, Nepal's disaster response policies are governed by the over-three-decades-old 1982 Natural Calamities Relief Act. Though a 2008 draft act envisaged a National Disaster Management Authority, it is yet to be ratified by parliament.

'The hope now is that with all the international resources and goodwill pouring in, Nepal can build a stronger national disaster preparedness policy and mechanism,' Fagan said.

Learning lessons from the region

Regional disaster experts agree with that assessment.

'First the funds need to be used for recovery interventions,' explained SI Arambepola, director of the Asian Disaster Preparedness Center in Bangkok. 'But a part of the funds should be used to develop a road map for a disaster-resilient Nepal.'

'The document would also identify the roles and responsibilities [of various government agencies] in implementation, ensuring that the government initiates a long-term plan for disaster risk reduction with the support of the development community,' the expert told IPS.

Such a document would specify which branches would issue warnings, which would disseminate them and which would be in charge of evacuations, for instance.

Arambepola also believes Nepal could learn a thing or two from its neighbours, no strangers to natural disasters. 'Nepal should take the example of other South Asian countries such as India, Pakistan and Sri Lanka to develop policy [and] legal frameworks and an institutional set-up for disaster risk reduction,' he stressed.

Sri Lanka in particular presents an excellent case study, since it was just 10 years ago that the country was caught in a similar crisis, completely at a loss to deal with the devastating impact of the 2004 Asian tsunami.

Whereas Nepal at least has been aware of the earthquake threat in its densely populated cities for many years, Sri Lanka had no idea that its coast – home to 50% of the country's 20 million people – was in such grave danger. It found out the hard way on 24 December when the killer waves knocked the stuffing out of 3% of its population, leaving 35,000 dead, over a million destitute and a reconstruction bill of $3 billion.

The country's former secretary to the ministry of disaster management, SM Mohamed, described the tsunami as an 'eye-opener', sparking efforts at both government and civil society levels to ensure that the country would never again be caught off-guard.

While the road to stronger management and preparedness has by no means been a smooth one, Sri Lanka has nevertheless made great strides since that fateful day, including setting up the country's first ever Disaster Management Centre (DMC).

In the last decade the DMC has evolved into the main national hub for disaster preparedness levels as well as becoming the nodal public agency for relief coordination and early warnings in the event of a natural calamity. It has district offices in all 25 districts with personnel ready at any time for immediate deployment. In April 2012, the DMC was instrumental in efficiently evacuating over a million people from the coast, due to a tsunami threat.

'The Sri Lankan operation grew from scratch, and now it's at a somewhat effective level, [though] there are still gaps. Disaster resilience is more about lessons learnt by trial and error,' DMC Additional Director Sarath Lal Kumara told IPS.

Although Nepal's challenges are unique compared to some of the worst disasters in the region's history – with 600,000 flattened houses after the quake, compared to Sri Lanka's 100,000 following the tsunami, for instance – it still stands to take away valuable lessons that will hopefully prevent unnecessary damage and loss of life in the case of future catastrophes. – *IPS* ◆

Delayed truth, no justice

It was only in December 2014, almost 30 years after the end of military dictatorship, that Brazil's National Truth Commission, established in 2011, presented its final report. While the report does spell out the human rights violations that were committed between 1964 and 1985 and name names, its recommendations seem arbitrary and incomplete.

Kai Ambos and Eneas Romero

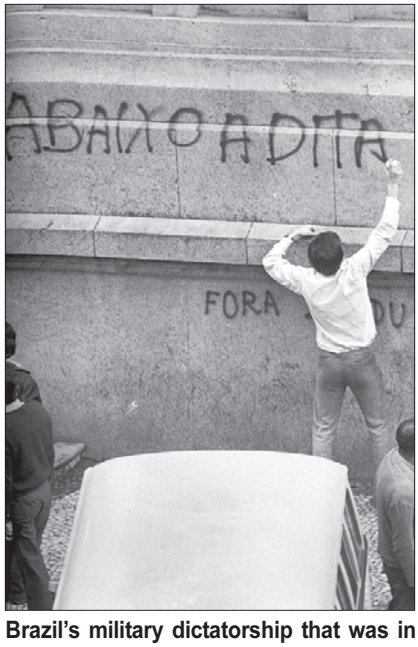
IN December 2014, almost 30 years after the end of Brazil's military dictatorship, the National Truth Commission (Comissão Nacional da Verdade – CNV), established on 18 November 2011, presented its final report. The report describes the human rights violations that were committed between 1964 and 1985 and names both perpetrators and victims. Its recommendations seem arbitrary and incomplete, however, and it is unclear whether the Commission even had a mandate to propose reforms.

In the first volume of its final report, the CNV describes the cruel and historically significant human rights violations perpetrated under the rule of Brazil's military junta after the coup d'état of 1964. The Commission discusses the bureaucratic structure of the dictatorship, including its many organs of repression. Supporting the extremely powerful national secret service, each ministry ran a secret service of its own. There were also several different police services, which made the systematic abuse of human rights possible.

Furthermore, the Commission sheds light on the close cooperation between the countries of the Southern Cone of South America (Argentina, Brazil, Bolivia, Chile, Paraguay and Uruguay). Starting in 1975, the military regimes of these countries agreed to secretly coordinate their brutal repression in a campaign called Operation Condor. The CNV also reports how military officers from Brazil were trained by the US Army School of the Americas.

The first volume identifies the four most important human rights violations:

- unlawful and arbitrary detentions,
- systematic physical and psychological torture, including rape and sexual assault,
- arbitrary and extrajudicial executions or other types of killings perpetrated by the state, and
- enforced disappearances.



Brazil's military dictatorship that was in power from 1964 to 1985 pursued an active policy of systematic human rights violations. Picture shows a student protesting the dictatorship in Rio de Janeiro in 1968.

The second volume contains contributions by individual members of the Commission, taking stock of human rights violations against specific groups (such as members of the military, workers, farmers, indigenous peoples and homosexuals) and institutions (like universities and the Church). It also illuminates the collaboration between the dictatorship and members of the business community.

The third volume of the report is of particular historical significance. It is dedicated to 434 individual victims, 191 of whom were killed and 243 disappeared. The report narrates the victims' lives and the circumstances of their deaths. It reveals that Brazil's military dictatorship pursued an active policy of systematic human rights violations.

The Commission does the right thing by naming names. The 377 suspects it identifies include eight former presidents of the dictatorship, all of whom are dead, as well as ministers of the navy, army and air force. The report also names businesses and entrepreneurs who collaborated with the regime. This process of 'naming and shaming' is a classic strategy of transitional justice. It is a first, albeit very cautious step towards coming to terms with the past in a serious way.

The CNV report is based on over 1,000 witness statements, which were made in 80 public hearings. Its documentation of the crimes of the dictatorship is an enormous achievement that deserves the highest respect. The CNV has made significant progress towards establishing facts and truth. Individual criminal trials would not have led to the same impressive results. The reason is that a truth commission unites experts from different fields of learning and is in a position to tackle the historical truth. Criminal trials, on the other hand, must focus on whether an accused individual is guilty or not, and the historical context is only taken into account to the extent needed to settle that question.

It is equally commendable that the report identifies structures that are still in place and create favourable conditions for human rights abuses.

To improve matters, the Commission's suggestions include reforming the curricula of police and military academies in order to promote democracy and human rights. Additionally, the CNV wants the government to repeal legislation that discriminates against homosexuals. It also highlights deficiencies in Brazil's code of criminal procedure and shortcomings of its law enforcement agencies.

A commission of impunity

The report also deserves some criticism, however. Since the Ministry of Defence and the armed forces did not support the CNV, the report contains little new information. The Ministry of Defence disclosed very few new documents, and the documents it did release mostly contained facts that were already known. Therefore, the report does not provide new insights.

More importantly, the CNV is likely to remain a commission of impunity. It was formed much too late and ultimately failed to overcome the greatest obstacle: the amnesty law of 28 August 1979. This law is standing in the way of comprehensive criminal prosecution of the perpetrators of Brazil's human rights violations. The amnesty law has never been seriously called into question, despite the fact that the current president, Dilma Rousseff, and her predecessors Lula da Silva and Fernando Henrique Cardoso were all victims of the dictatorship.

The armed forces continue to refuse to officially acknowledge that human rights violations took place. Some members of the military have even gone so far as to refer to the coup of 1964 as a 'revolution'. They wanted the CNV to investigate crimes committed by the opponents of the military regime. Military leaders even attempted to use legal means to prevent the report from being disseminated.

The Commission report is obviously putting some political pressure on the Brazilian justice system and the Supreme Court (Supremo Tribunal Federal – STF). The people who are suspected of committing human rights abuses should finally face trial. The report uncovers serious violations that constitute crimes against humanity. International law requires that such crimes be prosecuted and punished, and a national amnesty law cannot undo this obligation.

The CNV does recommend that the amnesty law be repealed. However, that recommendation will probably not be heeded because Brazil's Supreme Court has declared that the law is constitutional. It has thwarted efforts by the federal prosecution service and some federal judges to take perpetrators to court.

The Inter-American Court of Human Rights (Corte Interamericana de Derechos Humanos – CIDH), however, supports the Commission's point of view. According to a CIDH judgment of October 2014, Brazil is not fulfilling its obligations under international law to prosecute human rights violators. The important thing now is how new STF justices will view this question.

Nevertheless, it is surprising that the CNV's report does not recommend carrying out the usual, internationally recognised measures of transitional justice, such as cleansing the public sector of people with connections to the former regime. In Brazil, retired members of the military and others who were involved in human rights abuses continue to get state pensions and benefits without being subjected to criminal prosecution.

The CNV has many recommendations for Brazil (see box). But its approach seems rather half-hearted, since it does not even demand that all tools of transitional justice be used. It is not clear that the CNV had a mandate to propose broad reforms. As a result, its suggestions come across as arbitrary and incomplete.

Generally speaking, however, the Commission's report is laudable. It could go a long way towards changing Brazil's authoritarian mentality and strengthening its democratic institutions. The fact that the report includes the demand to prohibit celebrations of the 1964 coup shows that authoritarian thinking is quite persistent.

The CNV's report strikes a heavy blow against those who harbour nostalgia for the dictatorship and against inveterate defenders of torture. Nevertheless, the members of the military who perpetrated crimes and those who supported them in the administration have yet to be taken to account. The armed forces, moreover, still badly need structural reform. Delayed truth is better than no truth, and late justice is better than no justice. ◆

Call for action

THE lasting legacy of the CNV is its demand that Brazil fundamentally change the way it deals with human rights violations. The Commission makes three types of recommendations. It calls for institutional reforms, for constitutional and legal reforms, and makes suggestions on reform implementation.

Some recommendations are very general demands for Brazil to observe human rights. They include proposals to reform the prison system, strengthen the position of public defenders in legal proceedings and create an oral review procedure for preventive detention. Moreover, the Commission is in favour of limiting the jurisdiction of the military judicial system more stringently. At the level of federal states, moreover, it wants the military police to play no role anymore.

What is missing, however, is recommendations for a reform of the justice system in general and the public prosecutor's office in particular. Both are haunted by structural problems. The report also pays insufficient attention to external monitoring of police activities and the need to speed up criminal proceedings. ◆

Kai Ambos is a professor of international criminal law at the University of Göttingen in Germany and a judge at Landgericht Göttingen (delegated to Oberlandesgericht Braunschweig). Eneas Romero is a public prosecutor from Brazil and preparing his PhD thesis at the University of Göttingen under a DAAD/CAPES scholarship. This article is reproduced from D+C (Development and Cooperation) *(March 2015).*

From slavery to self-reliance

The struggle of Dalits – formerly known as 'untouchables' under India's caste system – for human dignity is still a tough one, but as the following story illustrates, the lot of women from the community is even more wretched.

Stella Paul

Stella Paul/IPS

BhagyaAmma, a Madiga Dalit woman and former 'devadasi', has found economic self-reliance by rearing goats.

HULIGEAMMA, a Dalit woman in her mid-40s, bends over a sewing machine, carefully running the needle over the hem of a shirt. Sitting nearby is Roopa, her 22-year-old daughter, who reads an amusing message on her cellphone and laughs heartily.

The pair lead a simple yet contented life – they subsist on half a dollar a day, stitch their own clothes and participate in schemes to educate their community in the Bellary district of the southwest Indian state of Karnataka.

But not so very long ago, both women were slaves. They have fought an exhausting battle to get to where they are today, pushing against two evils that lurk in this mineral-rich state: the practice of sexual slavery in Hindu temples, and forced labour in the illegal mines that dot Bellary District, home to 25% of India's iron ore reserves.

Finally free of the yoke of dual slavery, they are determined to preserve their hard-won existence, humble though it may be. Still, they will never forget the wretchedness that once defined their daily lives, nor the entrenched religious and economic systems in India that paved the way for their destitution and bondage.

From the temple to the open-pit mine

'I was 12 years old when my parents offered me to the Goddess Yellamma [worshipped in the Hindu pantheon as the "goddess of the fallen"], and told me I was now a "devadasi",' HuligeAmma tells Inter Press Service (IPS). 'I had no idea what it meant. All I knew was that I would not marry a man because I now belonged to the Goddess.'

While her initial impressions were not far from the truth, HuligeAmma could not have known then, as an innocent adolescent, what horrors her years of servitude would hold.

The devadasi tradition – the practice of dedicating predominantly lower-caste girls to serve a particular deity or temple – has a centuries-long history in South India.

While these women once occupied a high status in society, the fall of Indian kingdoms to British rule rendered temples penniless and left many devadasis without the structures that had once supported them. Pushed into poverty but unable to find other work, bound as they were to the gods, devadasis in many states across India's southern belt essentially became prostitutes, resulting in the government issuing a ban on the entire system of temple slavery in 1988.

Still, the practice continues and as women like HuligeAmma will testify, it remains as degrading and brutal as it was in the 1980s.

She tells IPS that as she grew older a stream of men would visit her in the night, demanding sexual favours. Powerless to refuse, she gave birth to five children by five different men – none of whom assumed any responsibility for her or the child.

After the last child was born, driven nearly mad with hunger and despair, HuligeAmma broke away from the temple and fled to Hospet, a town close to the World Heritage site of Hampi in northern Karnataka.

It did not take her long to find work in an open-cast mine, one of dozens of similar, illicit units that operated throughout the district from 2004 to 2011. For six years, from dawn until dusk, HuligeAmma extracted iron ore by using a hammer to create holes in the open pit through which the iron could be 'blasted' out.

She was unaware at the time that this back-breaking labour constituted the nucleus of a massive illegal mining operation in Karnataka state which saw the extraction and export of 29.2 million tonnes of iron ore between 2006 and 2011. All she knew was that she and Roopa, who worked alongside her as a child labourer, earned no more than 50 rupees apiece (about $0.70) each day.

In a bid to crack down on the criminal trade, police often raided the mines and arrested the workers, who

had to pay bribes of 200-300 rupees (roughly $4-6) to secure their release.

In a strange echo of the devadasi system, this cycle kept them indebted to the mine operators.

In 2009, when she could no longer tolerate the crushing workload or the constant sexual advances from fellow workers, contractors and truckers, who saw the former temple slave as 'fair game', HuligeAmma threw herself on the mercy of a local non-governmental organisation, Sakhi Trust, which has proved instrumental in lifting both her and her daughter out of the abyss.

Stella Paul/IPS

One of hundreds of illegal open-pit iron ore mines in the Bellary District that operated with impunity until a 2011 ban put a stop to the practice.

Today all her children are back in school and Roopa works as a youth coordinator with Sakhi Trust. They live in Nagenhalli, a Dalit village where HuligeAmma works as a seamstress, teaching dressmaking skills to young girls in the community.

Caste: India's most unsustainable system

The story may have ended happily for HuligeAmma and Roopa, but for many of India's roughly 200 million Dalits, there is no light at the end of the tunnel.

Once considered 'untouchables' in the Indian caste system, Dalits – literally 'the broken' – are a diverse and divided group, encompassing everyone from so-called 'casteless' communities to other marginalised peoples. Under this vast umbrella exists a further hierarchy, with some communities, like the Madiga Dalits (sometimes called 'scavengers'), often discriminated against by their kin.

Historically, Madigas have made shoes, cleaned drains and skinned animals – tasks considered beneath the dignity of all other groups in Hindu society.

Most of the devadasis in South India hail from this community, according to Bhagya Lakshmi, social activist and director of the Sakhi Trust. In Karnataka alone, there are an estimated 23,000 temple slaves, of whom over 90% are Dalit women.

Lakshmi, who has worked alongside the Madiga people for nearly two decades, tells IPS that Madiga women grow up knowing little else besides oppression and discrimination.

The devadasi system, she adds, is nothing more than institutionalised, caste-based violence, which sets Dalit women on a course that almost guarantees further exploitation, including unpaid labour or unequal wages.

For instance, even in an illegal mine, a non-Dalit worker gets between 350 and 400 rupees (between $5-6) a day, while a Dalit is paid no more than 100 rupees, reveals MinjAmma, a Madiga woman who worked in a mine for seven years.

Yet it is Dalit women who made up the bulk of the labourers entrapped in the massive iron trade.

'Walk into any Dalit home in this region and you will not meet a single woman or child who has never worked in a mine as a "coolie" [labourer],' Manjula, a former mine-worker turned anti-slavery activist from the Mariyammanahalli village in Bellary District, tells IPS.

Herself the daughter and granddaughter of devadasis, who spent her childhood years working in a mine, Manjula believes the systems of forced labour and temple slavery are connected in a matrix of exploitation across India's southern states, a linkage that is deepened further by the caste system.

She, like most official sources, is unclear on the exact number of Dalits forced into the iron ore extraction racket, but is confident that it ran into 'several thousands'.

Destroying lives and livelihoods

Annually, India accounts for 7% of global iron ore production, and ranks fourth in terms of the quantity produced after Brazil, China and Australia. Every year, India produces about 281 million tonnes of iron ore, according to a 2011 Supreme Court report.

Karnataka is home to over 9 billion tonnes of India's total estimated reserves of 25.2 billion tonnes of iron

ore, making it a crucial player in the country's export industry. Bellary District alone houses an estimated 1 billion tonnes of iron ore reserves. Between April 2006 and July 2010, 228 unlicensed miners exported 29.2 million tonnes of iron ore, causing the state losses worth $16 million.

With a population of 2.5 million people relying primarily on agriculture, fisheries and livestock farming for their livelihoods, Bellary District has suffered significant environmental impacts from illicit mining operations.

Stella Paul/IPS

Dalit women and their children, including young boys, are working together to end the system of 'temple slavery' in Karnataka state.

Groundwater supplies have been poisoned, with sources in and around mining areas showing high iron and manganese content, as well as an excessive concentration of fluoride – all of which are the enemies of farming families who live off the land.

Research suggests that 9.93% of the region's 68,234 hectares of forest have been lost in the mining boom, while the dust generated through the processes of excavating, blasting and grading iron has coated vegetation in surrounding areas in a thick film of particulate matter, stifling photosynthesis.

Although the Supreme Court ordered the cessation of all unregistered mining activity in 2011, following an extensive report on the environmental, economic and social impacts, rich industrialists continue to flout the law.

Still, an official ban has made it easier to crack down on the practice. Today, from the ashes of two crumbling systems – unlawful mining operations and religiously sanctioned sexual abuse – some of India's poorest women are pointing the way towards a sustainable future.

From servitude to self-reliance

Their first order of business is to educate themselves and their children, secure alternative livelihoods and deal with the basic issue of sanitation – currently, there is just one toilet for every 90 people in Bellary District.

The literacy rate among Dalit communities in South India has been found to be as low as 10% in some areas, but Madiga women are making a massive push to turn the tide. With the help of the Sakhi Trust, 600 Dalit girls who might have missed out on schooling altogether have been enrolled since 2011.

Today, Lakshmi Devi Harijana, hailing from the village of Danapura, has become the first Madiga woman in the region to teach in a college, while a further 25 women from her village have earned their university degrees.

To them, these changes are nothing short of revolutionary.

While some have chosen to travel the road of intellectual advancement, others are turning back to simple skills like sewing and animal husbandry.

BhagyaAmma, once an exploited temple slave who also worked in an illegal mine for several years, is today rearing two goats that she bought for the sum of $100. She tells IPS she will sell them at the market during the holy festival of Eid al-Adha – a sacrificial feast for which a lamb is slaughtered and shared among family, neighbours and the poor – for $190. It is a small profit, but she says it is enough for her basic needs.

Although the government promised the women of Bellary District close to 30 billion rupees (about $475 million) for a rehabilitation programme to undo the damages of illegal mining, the official coffers remain empty.

'We have received applications from local women seeking funds to build individual toilets, but we have not received any money or any instructions regarding the mining rehabilitation fund,' Mohammed Muneer, commissioner of the Hospet Municipality in Bellary District, tells IPS.

Not content to wait around, the women are mobilising their own community-based scheme, which allocates 15,000 rupees (about $230) on a rolling basis for families to build small toilets, so that women and children will not be at the mercy of sexual predators. Also in the pipeline are biogas and rainwater harvesting facilities.

As Manjula says, 'We want to build small models of economic sustainability. We don't want to depend on anyone – not a single person, not even the government.' – *IPS* ◆

The Peruvian poet *Javier Heraud Pérez* (1942-1963) was one of the most promising poets of his generation. At the age of 19, he won a prestigious national literary award for his second book of poems. His uncompromising political commitments led to his untimely death two years later.

Ars poetica

Javier Heraud

In truth, and frankly speaking,
poetry is a difficult job
that's won or lost
to the rhythm of the autumnal years.

(When one is young
and the flowers that fall are never gathered up,
one writes on and on at night,
at times filling hundreds and hundreds
of useless sheets of paper.
Once can boast and say:
'I write without revising,
poems leave my hand
like Spring discarded
by the cypresses on my street.')
But as time passes
and the years filter in between the temples,
poetry becomes
the potter's art:
clay fired in the hands,
clay shaped by the quick flames.

And poetry is a marvellous lightning,
a rain of silent words,
a forest of throbbings and hopes,
the song of oppressed peoples,
the new song of liberated peoples.

So poetry, then,
is love, is death,
is man's redemption.

Translated by Elinor Randall

Credit: Shokoufeh Malekkiani

Siosepol, the Bridge of 33 Arches, in Isfahan, Iran.