

# Food for Subversive Thoughts

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**\*\*IF DEFENDING AND STRUGGLING FOR THE FULFILMENT OF THE RIGHT TO HEALTH IS CONSIDERED SUBVERSIVE, IT MAKES US SUBVERSIVE. THIS IS AN INVITATION. LET'S ALL SCHEME AND CHALLENGE!\*\*** (L.Weinstein)

-In the words of a Dean of Johns Hopkins University, work in the health sector requires the flexibility of an earthworm, the ability of a locksmith and the capability of mounting a grand indignation of a lawyer. (...in Philadelphia in the original quote).

1. The veritable crisis in health systems failure we see the world over should lead us to a re-think of the triumphalism that has marked some of the global health debate in recent years as the MDGs are evaluated. Some even project a 'grand convergence within a generation' between North and South --rich and poor countries-- based upon predictions of 'an end of preventable mortality, including that from infectious diseases'. The truth though is that health systems in too many countries are and have been dysfunctional --way before Ebola hit. (i) Health facilities are often a place where people, especially women and children, experience first-hand their poverty and marginalization. (A.Yamin)

(i): Is ebola the terrorism of the poor...? (P. Farmer)

**\*\*The greatest attribute of health (and of the right to health) is to desire it.\*\*** (L. Weinstein)

-Yes, we desire universal health coverage. But what must we do when UHC means different things to different people? ...and is not in line with human rights?

2. A question that remains ever unasked is whether the 'communitization' of health services in diverse contexts is the real desirable alternative to their privatization; it certainly is the mean to heighten and boost the 'publicness' of health services. (A. Shukla)

3. However, it is more. Not only do we not ask the preceding question but, as a corollary, we actually do not actively enough identify and use effective means to tackle the 'commercial determinants' of preventable ill-health, malnutrition and deaths. This, despite the fact that it is now increasingly recognized that the key political debates in public health revolve around countering the primacy of economic over social policies as a consequence of the reign of neoliberalism. (I. Kickbusch)

4. Current health systems, with their data collection and (little) use, their practices and their tools cannot just result-in and be satisfied-with coming up with yet more technical 'recommendations', 'guidelines' and 'model programs'. Why? Because the subjects of health care delivery systems are people and communities with real every day problems, with needs and with desires anchored in very concrete contexts. Their problems cannot be dealt with numero-statistics used in tables and elegant figures that 'describe' and perhaps monitor trends in health situations. These statistics often only mask or scratch the surface of the real problems at hand. Little is done to 'take charge' of the latter to really address them in a truly disaggregated, participatory and human rights-based way. (G. Tognoni)

5. National health services said to be centered on primary health care have been 'reorganized' through waves of liberalization, privatization and disease-focused verticalization, as well as through performance-based financing and many other reforms. As a result, people have come to services to find new rules for what is free and what is charged, for what medicines and supplies are present and which are not.

Furthermore, community health activities and community health workers have appeared, disappeared and appeared again. The problem lies in the application of biased forms of knowledge that subdue others, in practice excluding and disempowering these others from the creative processes that have a much better chance to transform society.

6. What is really scary is that this also fosters the tendency for ordinary people to be the last to know and care about the waves upon waves of reforms transforming their health systems. Action cannot grow out of knowledge and options conceived in distant corridors.(ii) Those affected by the problem are the primary source of information and thus the primary actors that can truly generate, validate and use the knowledge needed for lasting, sustainable action(s). It is rather a problem when the knowledge used to guide this change does not draw on the experience, knowledge and wisdom of those directly involved, through methods that build their sovereign power to inform, to learn-from and to shape the needed changes.(iii) (R. Loewenson) This is why some of us are now speaking of health sovereignty (as in food sovereignty).

(ii): Knowledge tends to drive out wisdom.

(iii): Authoritarianism and obedience go together with an a-critic and rigid thinking; they also go together with disqualifying the weak and minorities; with stereotyping and prejudice; with a lack of tolerance that brings about permanent conflict between a spirit of service and the currently predominant mercantile mentality of so many health planners. (L.Weinstein)

\*\*Human rights applied to health aim at personalizing subjects that are actively being made to be impersonal, i.e., at personalizing a population-level intervention.\*\* (M. Debartolo)

7. Many of you have heard the call for Health in all Policies (HiaP) as a purported vehicle to fulfill the right to health and to achieve greater equality. It is centered in calling for greater 'policy coherence' --just otherwise defined. HiaP has a ring of the ancient call among us for a multisectoral approach only now insisting to give health a greater deserved attention.(iv) The question, of course, is which kind of health are we to more aggressively promote. It is no secret that in the world we are divided on this issue. There is a clear North/South gap; there is a gap between what we in public interest civil society want and what charter-based UN agencies want; a gap between what international NGOs and public interest CSOs and social movements want. Worrisome is the fact that each group will continue pushing their vision of which health and HiaP to promote. I am afraid we cannot sweep the politics of it all under the rug anymore. We cannot make progress when different breaks are on; we need full speed.

(iv): Being skeptical, I ask coherence for and between what? Public interest CSOs and social movements will continue to fight such coherence when just understood as multisectoral coordination without a call for structural reforms; they will lean towards approaches closer to those made in Brazil.

8. The collective social action needed for the right to health to be respected and fulfilled shows us that there are three types of mobilization: (a) the rejection of the imposition of health policies related to a neoliberal health system model that commoditizes health and privatizes the social security and health systems (e.g., Mexico, Colombia and Peru); (b) the active defense of public social security systems and of universal health care systems under threat by a commoditization and privatization drive (e.g., Brazil and Costa Rica) and (c) the autonomous proposition of communities resisting and generating their own forms of health care and of the protection of life (e.g., Chiapas in Mexico, Chimaltenango in Guatemala and Cochabamba in Bolivia). (M. Torres)

\*\*The challenge we face in health care reform thus is to set up a universal health system based on the human right to health.\*\* (M. Rios)

9. Health sector reform has for long been a citizens demand because, in so many places, the current

system has for practical purposes collapsed. The way the system is organized does not respond to the needs of people and, therefore, violates their rights. The challenge thus is to come up with a health system that, by building on human rights principles, addresses solemn international obligations and national promises, agreements and even constitutional mandates.

Therefore, in the debates about health sector reform, it is no longer postponable to incorporate the following measures to unequivocally strengthen the role of the state:

- o in its health governance function (as relates to stricter and enforced health regulations);
- o in public health care financing (increasing the state's share in the financial protection of the most vulnerable, increasing health expenditure to at least reach the average of the countries in the region);
- o in the delivery of health care services (improving health infrastructure networks including physical, personnel and equipment needs);
- o in truly implementing comprehensive primary health care services and securing referrals to secondary and tertiary care facilities according to need and not capacity to pay;
- o in guaranteeing quality of services (security in the services for patients, as well as for staff, protection of the rights of patients and of labor rights with clear recourse mechanisms to seek restitution when appropriate);
- o in setting up regular support supervision functions of the actual provision of services;
- o in enhancing the capacity of regulatory and supervisory structures to carry out their duty;
- o in respecting the binding character of participation and representation of claim holders that allows them to actively participate in the policy decision making process at the national, regional and local levels of government (with claim holder representation being 50%+1 in the lower decision making levels);
- o in respecting the participatory surveillance and monitoring role of claim holders in the delivery of health care services;
- o in bringing together and eventually unifying the different existing sub-systems of health care financing and health care delivery (as well as strengthening the capacities needed in each of these sub-systems so as to facilitate their evolution towards true complementarity);
- o in guaranteeing that financial and other resources are made available to make universal health coverage a reality for all (with those who have private or social health insurance schemes paying their premia in part subsidizing the state's own funds allocated to those who cannot afford health care costs);
- o in curbing corruption;
- o in guaranteeing access to generic medicines;
- o in reinforcing the social security system aiming to reach the ILO's recommendation of 12% of wage contributions to this function (includes democratizing the management of social protection services with meaningful workers' participation and representation with a binding character);
- o in the state assuming the remuneration of the majority of professional and overall health staff;
- o in eliminating any bonuses paid out-of-pocket by patients;

- o in eliminating any barrier to access to health care based on any previous administrative or bureaucratic requirements that interfere with the fulfillment of the human right to health; (no citizen must die or her/his health and economic situation be aggravated by any perfectly treatable disease);
- o [in national human rights bodies closely monitoring the elimination of barriers and keeping vigilant about ministry of health decisions that endanger the fulfillment of the right to health especially when reform measures are regressive towards commoditizing the delivery of health services]. (M. Rios)

10. It is fitting to end this Reader by reminding us of Latinamerica's 'Five Ds in the Struggle for Health'. They are: Decolonize our thinking, Demedicalize life, Decommoditize health, Deindustrialize development and Dignify life. (ALAMES)

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**\*\*Postscript/Marginalia\*\***

-Now more than ever, we need more critical insights about the MDGs pertaining to health with their serious shortcomings, as well as the courage to apply human rights to health beyond them being a legal paradigm.

-Some top down ideas ought to begin at the bottom; then rise like the sun. (J. Koenig)

-Science and technology cannot put order in our lives; it is values that put order in our lives. (Albino Gomez)