Civil Society Response to the Draft
Interim Statement of the Commission on Social determinants of Health

The following points were placed before the Commission on Social Determinants of Health from the Civil Society Facilitators:

1. The Civil Society facilitators are very grateful to Sir Prof. Michael Marmot, the chairperson of the Commission on Social Determinants of Health and the UCL-CSDH secretariat for circulating the draft Interim Statement to the Civil Society facilitators. We value this action as it enhances optimum engagement and integration amongst the Commission's different streams.

2. We fully appreciate the outstanding efforts involved in developing the draft Interim Statement of the Commission on Social Determinants of Health headed by Sir Prof Michael Marmot.

3. The Civil Society facilitators endorse the Interim Statement of the Commission on the whole, but with the following provisos:

- The definition of Health: we believe that health should be clearly defined throughout the report (including its introductory section) as "a fundamental human right" instead of "a basic human need". This is not a simplistic issue of preferred phraseologies. Instead, it is of crucial importance as rights are conceptually different to needs, in shaping the entire manner in which all needed measures must be taken to meet those rights.

- Health should be described clearly as a "public good" and not simply as a "good". Explicitly describing health as a public good, from our point of view, means that people's health is not another commodity (good) and cannot be left to market forces and the domination of profit logic.

- The trends and impacts of the manifestations of neo-liberalism have been addressed in different parts of the Interim Statement. However, we believe that the dynamics described should be clearly named for what they represent, namely "Neo-liberalism". Consequently, we firmly believe the final report of the Commission should detail the public policies needed to address the social determinants of health in order to overcome the neo-liberal model and its effects on health equity and other vital spheres

- We strongly call upon the Commissioners in their final Interim Statement to thoroughly address and emphasize the serious negative impacts of dominant commercialization and privatization trends on people's health and health equity all over the world. There is abundant evidence to support these extremely serious trends, generated through the CSDH process (particularly the Knowledge Networks) as well outside it.

- We highly appreciate that the Draft Interim Statement has tackled militarization as one of the major determinants of people's health. We believe that the final Interim Statement should also go further to address the roots of militarization, as one of the neo-liberal processes affecting human dignity and health.

- We strongly call upon the commissioners to address, in their final Interim Statement, the negative impact of the unnecessary and unacceptable high profits of the pharmaceutical transnational corporations on people's access to medicines and other healthcare products.

In this manner, the final Commission Report can stress the importance of - and strongly recommend the need for - establishing/strengthening the public non-for-profit research-based pharmaceutical industry as one of the policy alternatives in which the WHO must play a central role.

- We strongly call upon the commissioners, in their final Interim Statement, to address the negative impact on people's health of the current "health global governance" dominated by the for-profit industry and healthcare service providers. The Final Report, therefore, needs to call for and address concrete ways of better democratization of global governance of health.

- We strongly call upon the commissioners, in their final Interim Statement, to address the negative impact of health workers migration to developed/rich countries as one of the striking factors affecting people's health in developing countries.

The responsibility of these developed/rich countries for this brain drain should be noted in the report, as well as highlighting the poor employment conditions of a large majority of these migrants.

- Civil Society acknowledges the Primary Health Care strategy to be even more valid today than in the 70s and calls for an explicit reference of the social determinants of health as an integral and indivisible component of the PHC as enunciated almost 30 years ago in the Alma Ata Conference and which is in a timely process of renewal by WHO.

Written by Amit Sen Gupta

Right to Health:
Going Beyond Health Care ***WHO, CSDH and Civil Society***

Perhaps for the first time, civil society has been granted an important role by WHO in the Commission on Social Determinants of Health. CSOs took their role seriously and planned and conducted a series of participatory and broad based exercises in all the regions. PHM was offered a crucial role by the then and late lamented DG, Dr. Lee and was able to play a significant part in making people's participation possible. It is well to take a look at some of the factors underlying PHM's involvement as well as to challenge CSDH and WHO to follow through on the decisions that would be made.

The Committee on Economic, Social and Cultural Rights, which monitors the Covenant and issues General Comments has rightly recognised that the right to health is closely related to and dependent upon the realization of other rights, such as the rights to food, housing and freedom of movement. The Committee has also interpreted the right to health as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, expressly noting an adequate supply of food and nutrition, as well as access to safe and potable water and adequate sanitation as key determinants; in other words, they are determinative of the extent to which one can enjoy the best attainable standard of health.

We look upon the Commission on Social Determinants of Health as the appropriate medium for extending this analysis of the Committee. At present General Comment 14 of the UN Committee on Economic, Social and Cultural Rights, adopted in the year 2000

(see Annexure I) is not a binding instrument . We strongly urge the Commission to add its analytical weight towards recommending that Comment 14 is transformed into a binding commitment by signatories. Further, the Commission needs to recognise and articulate the impact of global factors that impinge upon the enjoyment of the right to health in all nations across the globe. These factors would include: ***Those Related to Health Care and Services***

* Health systems: The effect of globally-promoted health system reforms of the past two decades on equity in access to care through changes in financing, delivery and privatisation. There is need to establish universal norms regarding a basic standard of essential health care services that must be ensured.

* Health workers: The impact of the global migration of health workers from countries in greater need to countries with greater resources on the Health, and mitigating policies to reduce global health inequities arising from such flows.

* Trade in health services: The role of trade liberalisation in health services in impacting on global health equity.

* Access to Essential medicines: The effect of extension of intellectual property rights on access to essential medicines, and alternative policies to ensure such access is not compromised.

Other Determinants of the Right to Health

* Water/sanitation: Globalisation's role in modifying access to potable water and sanitation, and measures that can ensure and safeguard equity in access and sustainability in use.

* Food security: The effect of an increasingly integrated global market in food production, marketing and distribution on food security at the national level and at the level of households.

* Economic Sanctions: Their use by nation states and international organisations and the impact on the right to health.

* Labour and Employment: The impact of globally integrated production systems on labour markets, unemployment, conditions of employment and social security linked to employment.

* Poverty: The impact of neo-liberal policies in the distribution of poverty between nations and within nations

* Gender: Global factors determining the position of women in society in different settings and their changing roles superimposed in existing inequities

* Social Exclusions: The role of neo-liberal globalisation in creating new kinds of exclusions and reinforcing existing ones.

* War and Militarisation: The impact of militarisation and war (or the threat of military aggression) on the right to health. An unraveling of the above would clearly lead us to

examining the social determinants of health that the Commission in seized with. We look towards the Commission to strongly locate its recommendations in the Rights framework, in a manner that places concrete demands on governments to act.

Empowerment for Health

Empowerment is a social and political process. Few would disagree that if the goal is to address Health inequity, strategies would need to be located in processes that empower people and rescue them from a situation that places them in various degrees of dependence. To put it in another way, people's Health can be ensured in the long term only if people have control over their lives. While there needs to be little or no debate to establish that debate on what we mean by empowerment and what are the processes that lead to this desired objective.

The term "empowerment" has become an integral part of the discourse of most agencies linked to the state or to multilateral agencies, and even donor agencies. It is necessary, however, to examine whether the liberating potential of the concept is retained during such usage. We would define empowerment as a concept that challenges established hegemonies and bases itself in a discourse that recognizes basic rights. When we talk of empowerment in the context of health, we recognize the need for people to be aware of conditions that affect their health. But we also would assert that empowerment is not just knowledge. It is the recognition and the building of abilities to change power relations in society. For, ultimately empowerment is about power. So we would also assert that power is not something that is voluntarily by established hegemonies, it is something that ahs to be fought for and won. It is, thus important to understand that outside agencies cannot and do not "empower" anybody.

They may facilitate, or help create favourable conditions. But ultimately it is the people who wrest power and thereby empower themselves. This distinction is important for us as it demarcates itself from the position that it is possible to empower people or communities.

Turning specifically to Health, what do we mean when we talk of empowering people to achieve Health? We do not just mean helping people to improve access to services or even just helping people to improve their conditions of living. These are important but do not change power relations.

Empowerment to achieve health means wresting the power to fundamentally change the causes of inequity. Thus empowerment for health is a process by which disadvantaged people work together to increase control over events that determine their health. Using a social determinants lens to define health, this means gaining the capability and the power to change economic relations, conditions of work and living, and access to resources.

Ultimately it also means the ability to change global power relations that determine Health. If we were to explain the concept with greater clarity by the use of an example, let us consider the seemingly simple task of empowering a community to prevent deaths among children due to diarrhoea.

At the first level, empowerment of a community to prevent diarrhoeal deaths would require access to knowledge - very importantly the knowledge to recognize symptoms of dehydration and the ability to prepare oral rehydration solution at home or locally. This is very important but addresses a small part of the problem if children are to still continue

living in conditions that make them vulnerable to repeated episodes of diarrhoea. A higher level of empowerment would require the community to be able to organise and demand better access to clean drinking water and sanitation facilities. At another level it would require the community to be able to articulate and fight for policies that ensure access to food and control over land. Even this may not be enough, and the process of empowerment may have to extend to the ability to change global policies that give rise to inequity and the unequal distribution of resources.

In the current global context that is dominated by the neo-liberal paradigm, the struggles for health, development, and social justice, even in a remote village or slum, are inseparable from the global struggle for a more just world economic and social order. In our view, thus, empowerment is a complex social and political process. In its essence resides the entire spectrum of power relations and the processes required to change existing relations.

With thanks to Amit Sen Gupta