



RIGHT TO HEALTH

#PublicHealth4All



PEOPLE OVER PROFIT:

END POLICIES THAT

UNDERMINE HEALTH FOR ALL

Volume 2 Issue 1 2019



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For more information on the campaign and to subscribe to *Right to Health*, visit our webpage: <http://www.world-psi.org/PublicHealth4All>. You can also send us stories, or make further enquiries. To contact us, Tel: +33(0)450406464; Email: baba.aye@world-psi.org. www.world-psi.org.



PEOPLE OVER PROFIT: END POLICIES THAT UNDERMINE HEALTH FOR ALL

I am happy to welcome you to this new volume of the Right to Health. As the PSI newsletter for our global Right to Health campaign, over the past two years it has brought you news of the work PSI and its affiliates are doing across the world, to ensure every woman, man and child can access quality public health. We intend to do this even better.

PSI's vision is one of a better future, based on social and economic justice, and efficient, accessible public services around the world. Campaigns to influence policy internationally and nationally is thus central to our work. The Right to Health Quarterly serves as our voice to advance the goal of universal public healthcare.

The human right to health¹ means that everyone has the right to the highest attainable standard of physical and mental health, which includes access to all medical services, sanitation, adequate food, decent housing, healthy working conditions and a clean environment. This right is protected in **several international conventions, and reflected in the constitutions²** of at least 115 countries.

It is however clear that most people, particularly in low- and middle-income countries, are denied this fundamental right in practice. To ensure “the enjoyment of the highest attainable standard of health” becomes a universal reality, governments and international institutions

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need to promote and implement policies which put **People Over Profit**.

In this edition, we look at how policies such as austerity measures and international financial institutions' conditionalities undermine the right to health, and call for an end to such neoliberal policies. It is impossible to attain the targets or to “**ensure healthy lives and promote wellbeing for all at all ages**”³ by 2030 within the neoliberal policy framework.

PSI represents over 14 million health and social care workers in 270 unions across 152 countries and territories. Our members bear the burden of cuts in the funding of healthcare and the marketisation of health services as workers and as members of their communities.

But we are not mere passive onlookers. We are actively organising to change the situation for the better. As you will see in several stories from all the regions, we are at the forefront of the struggle to realise the right to health.

We are not doing this alone. We continue to build alliances and forge coalitions with communities, civil society organisations and well-meaning decision-makers, including legislators. And one of the lessons to be learnt from many of these stories is that when we are united and determined, we can win.

Ending all policies that undermine health for all will be a well-deserved victory for billions of people who today cannot access quality health, or who face catastrophic health expenditure.



Rosa Pavanelli
PSI General Secretary

1. <https://www.nesri.org/programs/what-is-the-human-right-to-health-and-health-care>
 2. http://www.world-psi.org/sites/default/files/en_concept_note_draft_2.pdf
 3. <https://www.who.int/sdg/targets/en/>

EURODAD REPORT

IMF

CONDITIONALITIES

PROMOTE UNHEALTHY

CONDITIONS



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A report by EURODAD investigates the IMF policy of attaching policy conditions to its loans. Not only do these conditionalities undermine the sovereignty of countries that receive IMF loans, they also promote austerity measures to detriment of public services.

INTERNATIONAL

PSI has consistently argued that international financial institutions (IFIs) contribute to undermining the realisation of the right to health, particularly in low- and middle-income countries. A report titled *Unhealthy conditions: IMF loan conditionality and its impact on health financing*¹, issued at the end of last year by the European Network on Debt and Development (EURODAD) confirms this perspective, and draws global attention to the fact that such bad practice might be getting worse.

The focus of this EURODAD research was the International Monetary Fund (IMF) practice of attaching policy conditions to its loans, particularly for crisis-hit countries. It investigated the conditions attached to IMF loans for 26 country programmes that were approved in 2016 and 2017. Its findings were compared to those of a previous study of the Network covering IMF programmes approved in 2011 to 2013.

Contrary to the IMF's stated commitment to streamlining its conditionalities and limiting these to

considerations of macro-critical resilience, conditions for loans and reviews of loans have been on the increase. The 26 programmes together had 227 quantitative conditions (i.e. an average of 8.7 per programme) and 466 structural conditions (i.e. an average of 17.9 per programme). Meanwhile, the average number of conditions per loan in between 2011 and 2013 was 19.5.

Quantitative conditions for IMF loans, otherwise described by the institution as quantitative performance criteria (QPCs) “relate to

macroeconomic variables² under the control of the authorities, such as monetary and credit aggregates, international reserves, fiscal balances, and external borrowing". Structural conditions, or Structural Benchmarks (SBs) as they are called, involve **economic reforms**³ that require legislation and critical policy changes.

These conditionalities undermine the sovereignty of countries which receive IMF facilities. They tend to promote austerity measures, with cuts in the funding of public services, such as healthcare delivery.

The EURODAD report further points out that:

"There are many pathways through which IMF conditionalities impact on health systems and access to health services – in particular, debt service payments, fiscal deficit reduction and limitations to public sector employment."

Much needed funds for health services get committed to debt service payments. And to meet fiscal deficit targets set as quantitative conditionalities, governments are constrained to constrict public health expenditure. Indeed, in 23 out of the 26 country programmes, "financial consolidation" (auphemism for austerity measures) is clearly spelt out in the programme objectives, policies and strategies.

The continued neoliberal thrust of IMF loan facilities undermines the possibility of achieving the Sustainable Development Goals. Health is a fundamental poverty-related sector which is particularly vulnerable to decreased spending. Debts incurred by less developed countries is generally considered by the IMF in macroeconomic


terms with little explicit account taken of the link between debt and the achievement of social development goals.

Reviewing the impact of IMF programmes in 21 countries over two decades, researchers demonstrated in 2008 that IMF programme conditionalities are associated with worsening health outcomes. And in 2015, it was established that decades of prioritising debt payments over investment contributed significantly to the devastating extent of the Ebola outbreak's impact in Guinea, Liberia and Sierra Leone. **Health services had been starved of investment**⁴, including vital public health infrastructure, undermining crisis preparedness in what were already fragile health systems. Not less than 11,315 lives were lost as a result.

The continued promotion of unhealthy loan conditionalities by the IMF cannot be allowed to continue. A fundamental change in approach is required. PSI shares the policy recommendations of EURODAD: expansion of fiscal space through debt restructuring as a first option, and demonstrable respect for states' democratic ownership of their policy instruments.

IMF loans are meant to help member countries tackle balance of payments problems⁵, stabilize their economies, and restore sustainable economic growth. Thus, countries turn to the IFIs when they have economic problems.

Addressing economic challenges must, however, not be at the cost of social wellbeing. A better future is impossible without health being realized as a fundamental human right. People and not profit must be at the heart of development for this to be sustainable and humane.

The IMF's debt sustainability assessments should thus be complemented with independent Human Rights Impact Assessments (HRIA). This will help ascertain the implications of debt burdens and ensure they are restructured to ensure countries can meet the targets of the Sustainable Development Goals and fulfil their human rights obligations to the people. 

1. <https://eurodad.org/unhealthy-conditions>
2. <https://www.imf.org/external/np/exr/facts/pdf/conditio.pdf>
3. <https://eurodad.org/files/pdf/1546182-conditionally-yours-an-analysis-of-the-policy-conditions-attached-to-imf-loans.pdf>
4. http://www.cadtm.org/spip.php?page=imprimer&id_article=11217
5. <https://www.imf.org/external/about/lending.htm>



THE IMPACTS OF AUSTERITY ON HEALTH

Health sector workers are affected in different ways by austerity measures.
©Per Flakstad

by Carolina Dantas

Austerity is a policy used by governments to save money, either as an overall reduction in government spending as a percentage of GDP (Gross Domestic Product), or specific reductions in government spending. However it is defined, austerity causes specific losses to specific people. It has become an issue especially in recent years, mainly in Southern Europe after the 2008 global economic crisis and in Latin America after the end of the commodity boom in 2012.

Governments justify austerity with a discourse saying it is necessary to promote “fiscal consolidation”, “fiscal sustainability” or “rationalize the public expenditure”, which in layman’s terms means to solve the fiscal deficit in a short term period, reduce the pressure of the external debt over the public budget, and by the fallacious financial unsustainability of social policies created by previous left-wing administrations. As a consequence, the

“solution” presented is a contraction of public expenditure, associated with labour, health and pension reforms.

International Financial Institutions (IFIs) hold a major role in recommending austerity measures; in Europe, the triumvirate, also known as the Troika, composed by the European Central Bank, the European Commission and the

IMF, enforced it. In Latin America, the Bretton Woods Institutions (IMF and World Bank) seem to be recovering their influence to recommend fiscal adjustment. An analysis of 27 European and Non-European countries, part of OECD, between 1995 and 2011 showed that the increase in public debt with IFIs, apart from its volume, is associated with higher cuts in health. (REEVES, 2014).

Health reform Measures by Region, 2010-15 (number of countries)

East Asia and Pacific	2
Eastern Europe/Central Asia	9
Latin America/Caribbean	2
Middle East and North Africa	3
South Asia	0
Sub-Saharan Africa	6
All countries	56

Source: Authors’ analysis of 616 IMF country reports published from February 2010 to February 2015

- The ILO, in joint research with the University of Columbia, launched a paper reviewing 616 IMF country reports in 183 countries, published between February 2010 and February 2015. The result shows that, following IMF prescription, reforms to the health sector are being considered by 56 governments in 22 developing and 34 high-income countries.
- Health sector workers are affected in different ways by austerity measures. These include: by adjustments in the wage bill to achieve cost-savings - under consideration by 130 governments across the globe - including non-adjustment of salaries in line with local inflation; by reductions in investment in public health care, that may lead to dismissals - reductions in medical personnel - and overload; by privatizations. And in many cases, they are even blamed for the existence of the crisis.

Austerity measures may include introduction or increase of user fees for health services, discontinuation of allowances and increased copayments for pharmaceuticals. These lead to increased out-of-pocket expenditure for health. Meanwhile, a lower quality of health service provision leads to worse health outcomes¹. The effects are especially intense in fragile health systems, worsening health inequities between as well as within countries.

Public health workers are not the only ones affected by cuts in health expenditure, service users also suffer. The hardest hit are those with low incomes, who cannot afford to pay for the services and so are excluded from or receive less critical assistance when their needs are greatest.

There is also a displacement of the effects of the crisis from the public sphere to households, which is commonly not seen in economic analyses. Women are

disproportionally more affected than men, and when the state does not provide welfare services it is usually the women who take charge of the care of elderly, sick people and children, through unpaid domestic work².

Other uneven effects of austerity measures are associated with weakened mental health, depression, anxiety, increased substance abuse, such as alcoholism and tobacco use, and higher suicide rates³. The European Centre for Disease Control warned that serious health hazards are emerging because of fiscal consolidation measures introduced since 2008.

One systematic review of the Greek economic crisis between 2009 and 2013 observed the following impacts on the health system of the country: reduction in public health expenditure in both the provision of services; reduction of the workforce in health, reduction of working hours, as well as wage and pension losses; reduction in the offer of health services, including the services provided by university hospitals; fluctuation of the pharmaceutical market, with an increase in consumption during the period observed - mainly medication for the treatment of psychiatric illnesses- followed by the decrease in the consumption, which led to the closure of some pharmaceutical factories in the country; reduction in the financing for biomedical research⁴.

Consequently, the quality of health services in Greece was affected, both by the restriction in service provision, as well as by the disposition of health staff, whose performance was jeopardized by the situation of stress in their private and professional lives. Nikolaos Grigorakis et al also call attention to the increase in out-of-pocket expenses to the Greek population, thanks to the obstacles preventing normal access to public health services. This is further intensified by the reduction of household income as a consequence of high unemployment, reductions in

wage and social assistance, and of the reimbursement of medical expenses from health insurance.

Countries such as Spain and Portugal, which implemented austerity policies, faced similar problems, while Iceland, where austerity was rejected by popular vote, increased investments in health, producing a different result⁵. According to Vieira, who did a broad revision of the impacts of economic crisis and fiscal austerity:

1. the economic crisis can aggravate the social problems and increase social inequalities;
2. the economic crisis can worsen the health status of the population;
3. the fiscal austerity measures, which establish the reduction of social protection expenditure aggravate the effects of the crisis over the health, particularly the social conditions; and
4. the preservation of social protection programs is an important measure to protect the health of the population and to recover the economic growth in a shorter period⁶.


The health and social protection policies are a factor that mitigates the effects of unemployment and/or reduction of work income. The countries which maintained or reinforced social protection policies, including cash transfer, during the periods of crisis, as a countercyclical measure, presented best economic and social performance, as well as less incidence of mental health and suicides.

An essential point in this discussion, for Latin Americans and other developing countries, is to learn from recent European experience the best ways to present solid and convincing results about the harmful effects of austerity on the health of the population, which is useful for collective bargaining.

PSI advocates for public, universal, rights-based, people-centred, and good quality health care.

Investment in health and social welfare is essential and is not a burden on public finances. On the contrary, health, social and medical-social activities are genuine creators of wealth and are affordable, even in the poorest countries.

The focus of the debate should always be on the people, not only on the expenditure. There are other alternatives to address the

current fiscal deficit that do not include cuts in public expenditure, but that include more progressive taxation and control over tax evasion and avoidance. Governments should sustain their commitments to public health, pensions and social services during the periods of crisis and introduce new schemes to extend health and social protection for all. 

1. See Karanikolos et al., 2013; Mladovsky et al., 2012
2. Bruff And Wöhl, 2015
3. See WHO, 2011; Stuckler and Basu, 2013 Simou & Koutsogeorgou 2014
4. Karanikolos, 2013
5. Schramm, Paes-Sousa & Pereira Mendes, 2018
6. Fernandez et al., 2015; Karanikolos et al., 2013; Kentikelenis et al., 2014;
7. Labonté E Stuckler, 2016
8. Barreto, 2018

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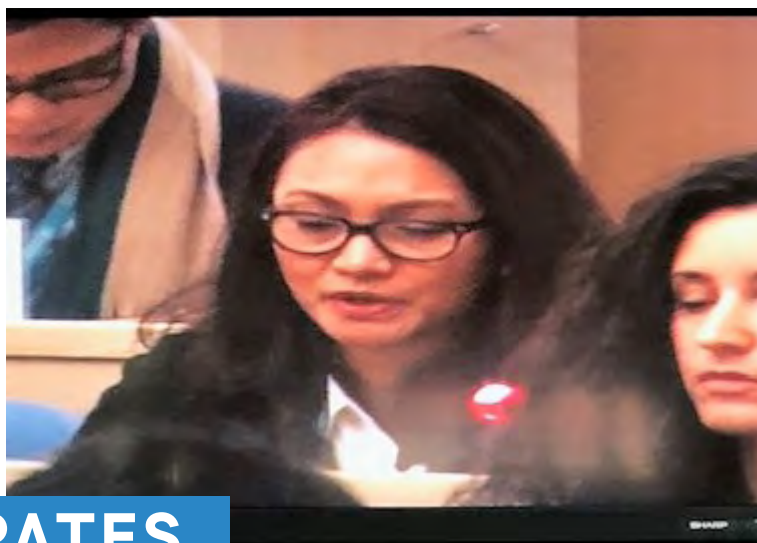
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A seven-person delegation from Public Services International (PSI) took part in the 144th session of the World Health Organization (WHO) Executive Board which took place in Geneva from 24 January to 1 February.

Genevieve Gencianos, PSI, spoke at the WHO Executive Board meeting.



PSI PARTICIPATES IN 144TH EXECUTIVE BOARD SESSION OF THE WHO

INTERNATIONAL

PSI was accorded official relations as a non-State actor with the WHO by the 142nd Executive Board in January last year. This allows us to participate in the governing bodies of WHO such as the Executive Board sessions, the World Health Assembly and meetings of the WHO Regional Committees.

The WHO Executive Board has 34 technically qualified members who represent WHO Member States and are elected for three-year terms. Other Member States can join the Board's deliberations, and non-state actors in official relations with the WHO, like PSI, are invited to submit written statements on agenda items.

In his report to the Executive Board¹, the WHO Director-General, Dr. Tedros Adhanom Ghebreyesus declared that the mission of the WHO under his leadership is “to promote health, keep the world safe, and serve the vulnerable”. The first step towards this is the 13th WHO General Programme of Work (2019-2023). The ambitious targets at the heart of this plan of work are: “1 billion more people benefitting from universal health coverage; 1 billion more people better protected from health emergencies; and 1 billion more people enjoying better health and well-being.”

The PSI delegation intervened on five crucial items on the agenda: “Implementation of the 2030 Agenda for Sustainable

Development”, “Primary health care towards universal health coverage”, “Health, environment and climate change”, “Human resources for health”, and “Promoting the health of refugees and migrants”.

On the implementation of the **2030 Agenda for Sustainable Development**², PSI pointed out that, while some progress had been made towards meeting the targets of the Sustainable Development Goals, “much more progress will be made with a reform of the global economic architecture”. As far back as 1978, Member States of the WHO called for a New International Economic Order at the historic Alma-Ata Conference, as a necessary step towards achieving “health for all by 2000”.

Two decades after the year **2000 target set at Alma Ata**³, health for all is yet to be achieved. The entrenchment of a neoliberal world order which puts profit before people has resulted in the commodification of health. We must now curtail global health companies' influence on international health. We need to establish a new order which puts people over profit and allows the right to health for all to become reality.

On primary health care (PHC) towards universal health coverage (UHC), PSI welcomed the WHO's renewed spirit "to deal effectively with current and future health challenges" and its people-centred approach with "emphasis on tackling the determinants of health".

We added that this reinvigorated vision of the WHO should encourage fiscal justice. To enhance domestic resource mobilisation for PHC, multinational corporations have to pay their fair share of tax, while low- and middle-income countries should be spared the burden of international financial institutions' "fiscal consolidation" conditionalities.

PSI also supported the **WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes**⁴, launched in October 2018, as a global policy framework for government. Community Health Workers have a major role in providing universal access to healthcare. Speaking on health, environment and climate change, PSI called for urgent action in the light of findings of the Intergovernmental Panel on Climate Change (IPCC) recent special report on "**Global Warming of 1.5°C**"⁵

Calls for funding of action on environmental health and climate change must take into consideration inequalities in wealth across regions. Countries and companies contributing to global warming must pay their fair share for our collective action to mitigate climate change, in line with the principles of social and generational justice.

In our intervention on Human Resources for health (HRH), PSI welcomed the launching of the **International Platform on Health Worker Mobility**⁶ (IPHWM) in October last year. The Platform was developed through dialogue and cooperation among WHO Member States, international agencies and stakeholders, such as employers, professional associations and trade unions. It is also part of the collaboration between WHO, the Organisation for Economic Cooperation and Development (OECD) and the ILO to implement the resolutions of the 2016 United Nations High-Level Commission on Health Employment and Economic Growth.

Finally, PSI intervened on promoting the health of refugees and migrants. We welcomed the alignment of the WHO Draft Global Action Plan 2019-2023 (EB144/27) with the **UN Global Compact on Refugees**⁷ and the **UN Global Compact for Migration**⁸.

We further highlighted three key points: the need to ground the Draft Global Action Plan on international human rights law; ensuring access of migrants and refugees to well-funded quality public health services, and safety and decent work for health workers, including frontline workers in conflict zones.

PSI will be building on these arguments at the World Health Assembly on 20-28 May 2019. It will also be an opportunity to deepen relations with civil society organisations and coalitions committed to the struggle for universal public health care such as the **People's Health Movement**⁹ (PHM) and the **Geneva Global Health Hub**¹⁰ (G2H2) in the series of CSOs meetings that precede WHO Governing Body meetings. □

1. http://apps.who.int/gb/ebwha/pdf_files/EB144/B144_2-en.pdf
2. <https://sustainabledevelopment.un.org/post2015/transformingourworld>
3. https://www.who.int/publications/almaata_declaration_en.pdf
4. <http://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-eng.pdf?ua=1&ua=1>
5. <https://www.ipcc.ch/sr15/>
6. <https://www.who.int/hrh/migration/int-platform-hw-mobility/en/>
7. <https://www.unhcr.org/towards-a-global-compact-on-refugees.html>
8. <https://www.iom.int/global-compact-migration>
9. <https://phmovement.org/>
10. <http://g2h2.org/>

2018 was a milestone year in international cooperation on the issue of migration and refugee protection, with the adoption by the UN General Assembly of two landmark global compacts, namely, the Global Compact for Migration and the Global Compact on Refugees.

UNITED NATIONS ADOPTS

TWO LANDMARK GLOBAL COMPACTS

ON MIGRANTS AND ON REFUGEES

by Genevieve Gencianos

The World Health Organization is building on this momentum, with the 144th WHO Executive Board preparing a Global Action Plan (2019-2023) on Health of Refugees and Migrants.

In December 2018, the United Nations General Assembly adopted the UN Global Compact for Migration and the UN Global Compact on Refugees. The compacts were adopted after two years of intensive consultations and negotiations. PSI actively engaged in advocacy and lobbying during these processes and welcomed their adoption¹.

The UN Global Compact for Migration is a robust framework of international cooperation to address the multi-dimensional aspects of migration.

The UN Global Compact on Refugees is a comprehensive refugee response framework that the

international community will undertake in order to ease pressure on host countries, enhance refugee self-reliance, expand access to third-country solutions and support conditions for safe and dignified returns of refugees.

Both Compacts affirm the human right to health for migrants and refugees and encourage stakeholders, including trade unions and civil society, to cooperate with governments and international agencies to realise this right, through a whole-of-society approach. PSI's Right to Health Campaign provides the vital tools with which we can promote the right to health in the Global Compacts. At the same time, our continued engagement in the implementation of the Compacts will provide the opportunity to enhance PSI's Right to Health Campaign in the context of migrant and refugee rights.

WHO DEVELOPS FIVE-YEAR GLOBAL ACTION PLAN ON THE HEALTH OF MIGRANTS AND REFUGEES

The WHO Director General, Dr Tedros Ghebreyesus, presented a draft Global Action Plan (2019-2023) on Promoting the Health of Refugees and Migrants to the 144th WHO Executive Board meeting in January. The Global Action Plan is an elaboration of the WHO Framework on Priorities and Guiding Principles to Promote the Health of Refugees and Migrants as mandated by the World Health Assembly resolution WHA70.15 of 2017.

The goal of the Action Plan is to assert health as an essential component of refugee protection and assistance, and of migration governance. The plan aims to address the health and well-being of refugees and migrants in an inclusive, comprehensive and holistic



Health workers caring for refugees


manner that takes into account the health of the overall population.

It recognizes that, in order to prevent inequities and inefficiencies, public health considerations of refugees and migrants are inseparable from those of the host population. Given that migration is a natural human feature, exacerbated by unprecedented levels of forced displacement arising from conflicts and climate change, the plan reflects the urgent need for the health sector to deal more effectively with the impact of migration and displacement on health.

The Action Plan outlines key priorities and options for action:

- Reduce mortality and morbidity among refugees and migrants through short and long-term public health interventions.
- Promote continuity and quality of care, while developing, reinforcing and implementing occupational health and safety measures.
- Advocate mainstreaming of refugee and migrant health in the global, regional and country agendas.
- Enhance capacity to tackle the social determinants of health and accelerate progress towards achieving the Sustainable Development Goals, including universal health coverage.
- Support measures to improve communication and counter xenophobia, and

- Strengthen health monitoring and health information systems.

The WHO Executive Board endorsed the Global Action Plan and submits it for adoption by the World Health Assembly in May 2019². 

1. See: <http://www.world-psi.org/en/psi-welcomes-adoption-un-global-compact-migration> & <http://www.world-psi.org/en/psi-joins-civil-society-welcoming-un-global-compact-refugees>
2. Read the full text of the Draft Global Action Plan on Health of Refugees and Migrants: http://apps.who.int/gb/ebwha/pdf_files/EB144/B144_27-en.pdf and read the PSI statement to the WHO Executive Board in January 2019 in response to the draft Global Action Plan [here](#).

The World Health Organization (WHO), International Labour Organization (ILO) and the Organisation for Economic Cooperation and Development (OECD) jointly launched the International Platform on Health Worker Mobility, in a first meeting held on 13-14 September 2019 at the WHO Headquarters in Geneva.

INTERNATIONAL PLATFORM ON HEALTH WORKER MOBILITY



Participants at the launch of the international platform on Health Worker Mobility

by Genevieve Gencianos

*Genevieve Gencianos is
the Migration Programme
Coordinator of PSI.*

PSI participated in the meeting, which was attended by 79 participants representing national governments, civil society, trade unions, employers' associations, national regulatory bodies, international credential verification organisations, and international agencies. The PSI representatives to the meeting included Baba Aye, PSI Health and Social Services Officer, Genevieve Gencianos, PSI Migration Programme Coordinator and Herbert Beck, who was also representing the European Federation of Public Services Unions (EPSU).

The aim of the meeting was to discuss existing policy measures and to identify strategic actions to strengthen the management and governance of health worker mobility. The Platform is one of the recommendations from the report of the United Nations High Level Commission on Health Employment and Economic Growth (UNComHEEG), where the PSI General Secretary Rosa Pavanelli is one of the Commissioners. Genevieve Gencianos presented the perspective of PSI on the issue of Global Skills Partnerships (GSP), which is a new form of skills

To read PSI's Analysis of the Global Skills Partnerships in the Health Sector:

http://world-psi.org/sites/default/files/attachment/news/web_2018_mig_report_mar-rakesh.pdf

mobility being promoted in the context of the recently adopted United Nations Global Compact on Migration. PSI is critically examining the concept of GSPs, particularly in the health sector, where demographic trends and health worker shortage will be driving health worker migration in the coming years. In her presentation, Gencianos highlighted core elements that should constitute any consideration of global skills partnerships, namely: tripartism and social dialogue, equity, sustainability and human rights, and the application of international norms and standards, including those contained in the WHO Global Code of Practice on the International Recruitment of Health Personnel, and the UN and ILO Conventions on Migrant Workers.

Throughout the two days of panel discussions and break-out groups, meeting participants identified strategic actions which included

strengthened information and knowledge exchange at the global level, capacity-building around bilateral agreements, review of the WHO list of countries with critical health shortages, enhanced policy and multi-sectoral dialogues at the national level and the development of knowledge repositories in areas relevant to health worker mobility (see full IPHWM Meeting Notes here:

<https://www.who.int/hrh/migration/platform-meeting-h-w-mobility/en/>).

This meeting is only the first among the activities of the IPHWM. PSI will continue to play an active role in the platform, bringing its concrete best practice example from the Germany-Philippines Bilateral Labour Agreement on Nurses, its pioneering analysis of the GSPs, and its broader global policy advocacy in the context of the UN Global Compact on Migration. □

LIBERIA:

TRADE UNION ACTIONS

ON DECENT WORK FOR

PEOPLE WITH DISABILITIES

While the international average number of persons with a disability (PWD) is 10%, in Liberia the number reaches 16%. The causes range from congenital conditions and birth trauma to accidents and sickness. The two civil wars in Liberia between 1999 and 2003 also caused an increase in the numbers of PWD. The Liberian Government is calling for actions to promote the cause and interests of PWD, including access to social protection and decent work.

by Faustina Van Aperen, ILO-Actrav

According to Morgan Ashenfelter (Handicap International), in his 2013 article [Changing Liberian Attitudes Toward the Disabled](#), “People with Disabilities have it tough in Liberia: Educational facilities do not cater to their needs, employment is difficult to find, sidewalks barely exist in the city and most businesses and government buildings do not even have a ramp... In addition, some disabilities, such as post-traumatic stress disorder or missing limbs, are stigmatized, as they are associated negatively with the war”.

There have been cases of families who abandon their disabled child, of rape cases of PWDs who are blind, deaf and dumb where the court of justice considers

that there is no way to provide evidence or identify their attackers, said Ambassador Daintowon Domah Paybayee¹ - an Advocate for the Missing Voices “Persons with Disabilities especially Women, Youth and Children” and Coordinator of African Youth with Disabilities Network in Liberia.

On a positive note, Liberia established the National Commission on Disabilities in November 2005, and adopted the National Decent Work Act. At the international level, Liberia has ratified 25 International Labour Conventions (only 14 are in still in force) including six out of the eight ILO Fundamental Labour conventions (the exceptions are C100 and C138). In 2012, Liberia ratified the United Nations Convention on rights of People with disabilities.

However, effective implementation of these international labour norms has still to become reality.

African Heads of State adopted a Protocol to the African Charter on Human and People’s Rights on the Rights of Persons with Disabilities in Africa on 31 January 2018. It has four strong provisions on people with disabilities’ rights: article 17 is Right to Work, article 14 is Right to Education, article 13 is Accessibility and Article 7 is Right to Life.

The Liberia Labor Congress held a joint workshop with the ILO Bureau for Workers’ Activities (ACTRAV) and the ILO Abuja office to support its members’ contribution to decent work for persons with disabilities on 3-6 December 2018 in

*Daintowon Domah
Paybayee, Advocate
for persons with
disabilities in Liberia*



Monrovia. The LLC invites its members to engage national social partners on the issue of decent work for persons with disabilities, especially their access to social protection and employment.

The workshop was attended by 35 participants, 20 guests from the Liberia Labour Congress and the groups representing People with Disability in Liberia. The opening session was attended by the Minister of Labour of Liberia, Honorable Moses Kollie.

The members of Liberia Labour Congress recognized that since the 14 years of civil war which ended in 2003, the nation has made significant progress towards decent work for all². But at the same time, they expressed their concerns about the lack of effective protection for people against social risks in their country (lack of assistance to children living with disability, aging, accidents, job loss, inadequate pensions...).

This situation means that persons with disability continue to be subject to social, economic and cultural injustice. The nation also deprives itself of the benefit of the 16% PWDs' labour contributions. The lack of an effective social protection system keeps the majority of PWD in a vulnerable condition, preventing them from enjoying

decent work for all and social inclusion.

The workshop reached the following decisions for action:

- Develop National Awareness Raising on decent work for and with people with disabilities.
- Hold partners meetings and engagements with line ministries, international partners and relevant social partners and groupings/institutions.
- Demand the government ratifies and implements ILO Conventions C138 and C100, with regulations that promote accessible employment within the private and public sectors for PWDs without discrimination, and ensure a legal framework and public services to support the implementation of ILO Conventions that have been ratified in relation to PWD.
- Ensure the Liberia Labor Congress engages relevant stakeholders and conducts a Labour Force Survey with full inclusion of the people with disabilities; to lobby government to ensure the establishment of a desk for people with disabilities at the Ministry of Labour to be headed by person with disabilities; engage employment institutions both in the private and public sectors to ensure decent work for PWD through social dialogue; work in collaboration with

line ministries (especially the ministries of Education, Health, Labour, Gender and Justice) to ensure people with disabilities are fully included and are not discriminated against in terms of education, employment and social protection.

In conclusion, People with Disabilities deserve a good health delivery system, education facilities, legal protection, a national social security coverage, and equal employment opportunities with equal protection under the law.

As children with disability and their mothers are the most vulnerable, they should be considered a national priority in the implementation of the national social protection system. Liberia Labour Congress calls on the Government and the Liberian Chamber of Commerce to join efforts in the building of a national social protection of children and their mothers, as an integral part of actions for decent work for all. □

1. Ambassador Daintowon Domah Paybayee, resource person at the LLC seminar 3-6 Dec 2018
2. <http://www.lr.undp.org/content/liberia/en/home/presscenter/press-releases/2018/persons-with-disabilities-want-inclusion-.html>

AFRICA AND ARAB COUNTRIES

GOVERNMENT SET TO REFORM KENYA'S HEALTH SYSTEM



Sicily Kariuki, Cabinet Secretary for Health and James Wambugu, Chair of the panel of experts. ©: Kenyan Ministry of Health

The Kenyan government has called on an independent panel of experts to help transform and reposition the National Health Insurance Fund (NHIF). Mr James Wambugu, a former insurance company manager, is leading the panel of experts. They have 90 days from 26 February to present a report, which will guide the country's progression to universal health coverage (UHC).

The NHIF is in dire need of reform and the government's commitment to UHC is commendable. But, building a strong public health system must be at the heart of any transformation process to realise quality health for all in Kenya.

The high administrative costs of running the Fund is the first challenge to overcome. It represents 22% of the funding available for NHIF against an average of 2,7% for social insurance funds globally.

Even more worrying is the fact that private health providers are benefitting the most. Kenyan

Members of Parliament recently pointed out that “**small private hospitals are the biggest beneficiaries of the NHIF millions.**”

Between July 2018 and 25 February 2019, about 1,266 private and faith-based health facilities claimed 2 billion Kenyan Shillings (US\$19,848,300) from the Fund. But, 5,751 public hospitals claimed just KSh789,002,629 (US\$7,830,170).

On average, a private provider drew US\$15,678 from the fund while a public hospital drew just US\$1,361: barely 9% of the average amount obtained from the fund by a private health provider.

In addition, most private health facilities are far smaller than the public hospitals, so the difference in funding per patient is even greater. Not even the prestigious public tertiary health institutions are spared.

The National West Hospital, which is the eighth largest private hospital in the country, was allocated KSh 147,362,358 (US\$ 1,462,440). But between them the two leading public health institutions in the country were allocated only KSh 155,933,682 (US\$1,547,510). These are the Kenyatta National Hospital, which is Kenya's oldest and largest hospital and the teaching hospital of the University

of Nairobi, and the 113-year old Moi Teaching and Referral Hospital.


Thus, we agree with Mr Wambugu that “the government has to come in²” to ensure provision of universal health coverage, because “it is their responsibility”. Improved public funding of health is a pressing need. For example, despite a gradual increment in budgetary commitment to health-care delivery over the years, the **Kenyan national and county governments have spent an average of just 7.1% on health³**. This is less than half of the 15% budgetary allocation commitment made by African Heads of States and Governments in the 2001 Abuja Declaration.

It is equally important to stop enriching for-profit interests such as insurance companies and private health establishments with public financing of health, especially while the immense majority of the population use only public health facilities.

A well-funded public health system is the cornerstone of health for all. And the public must have the opportunity to be active in governance of the public health system to ensure transparency and democratic accountability.

We welcome the words of Ms Sicily Kariuki, Cabinet Secretary for Health, who said when inaugurating the panel that government will “ensure that the reform process attains highest possible level of public participation”. PSI affiliates in Kenya will engage with the process and in line with the objectives of the Campaign for Public Health for All in East Africa launched last May in Nairobi. They will call for “a Human Rights Based Approach (HRBA) to the pursuit of Universal Health Coverage,” putting people over profit in reforming the NHIF in particular and the Kenyan national health system in general.

Kenya’s National Health Insurance Fund is undergoing reform, and the government has called on an

independent panel of experts to assist. The objective is for the country to progress to universal health coverage. The main issue must be the building of a strong public health system, putting people over profit. 

1. https://www.the-star.co.ke/news/2019/03/01/alarm-as-private-health-providers-file-huge-claims_c1901731_elbowing_out_major_public_health_facilities.”
2. <https://businessday.co.ke/insurance-captain-drive-nhif-overhaul/>
3. <https://pesacheck.org/how-much-of-kenyas-budget-is-going-towards-the-health-sector-5ee2040b1f5>

REALITY OF RIGHT TO HEALTH IN NIGER

Political Commitment Needed

by *Nouhou Mamadou Badjé*



*Nouhou Mamadou Badjé SGa2
/ BEN / SUSAS / Niger*

Guaranteeing the health of the Nigerien population is a constitutional obligation which is supposed to be binding on the government. The right to health is a fundamental human right enshrined in the constitution. As stated in Article 12, "Everyone has the right to life, to health, to physical and moral integrity, to a healthy and sufficient food, ..." But the reality thus far is quite different from the provision of the law.

Poor resources and inadequate priority for health by government, even with the resources available, has made life ever more difficult for 20 million people that live in our landlocked country in the West African sub-region. The share of the health sector in the annual budget has never been up to 10%. The result of this is that we have a very fragile public health system

Recently, the Nigerian state adopted a five-year Health Development Policy (PNS). This encompasses several programs, plans and projects which are meant to improve the health status of the populations.

The state and health authorities have recorded some achievements in the provision of health infrastructure. But these are grossly inadequate. And working conditions in the health sector remain terrible despite the much-vaunted achievements. While a few new

health centres have been built, they are crucially lacking in qualified personnel. 90% of health and social workers are contract staff or volunteers. Patients are crammed into treatment rooms and ambulatory services are almost non-existent. All these have resulted in loss of confidence of the populations in the health centres

To make matters worse, the state is disengaging more and more from the provision of health services. Private sector provision of health care is fast increasing. But it is impossible for most of the population, who are poor, to pay their charges. A lot of people thus have no option but self-medication or to turn to traditional healers with all the attendant dangers that go with these approaches.

The situation is notably worse in the rural areas. And these are the places where most Nigeriens live. Many women bleed to death¹ during or after giving birth in these areas because they cannot reach the health services

There are a few medical procedures that are supposed to be free, particularly for women and child care. But this makes no meaning in the absence of basic medical equipment and medicines. As a result, some of the gains in health outcomes that were made earlier in the decade, such as reduction of child mortality, are being reversed.

The trade unions, with PSI affiliates at the fore, and civil society organisations continue to call on the government of Niger to be more concerned about revamping the health sector in reality more than in rhetoric. But this has been to no avail.

Several international organisations and partners² including the World Health Organization have also given the government advice such as pointing out the importance of committing not less than 15% of the national and 8% of local authorities' budgets to health. Government has failed to respond positively to these suggestions. The public health system thus continues to sink into the abyss because of insufficiency of material, human and financial resources.

Beyond empty proclamations of progress being made, the Nigerien authorities must accord the health sector the paramount priority it deserves, to ensure citizens actually enjoy their legitimate right to health.

Health is priceless but has a cost!



1. <https://reliefweb.int/report/niger/reducing-health-care-inequality-adequate-primary-care-rural-communities-niger>
2. <http://uhcpartnership.net/towards-a-new-national-health-policy-in-niger/>

UNIONS, SOCIAL INEQUALITIES

AND THE SENEGALESE HEALTH SYSTEM

by Dr. Mbaye Kamara

From the 1980s, the Senegalese health system has evolved from a relatively modern and efficient system into a two-tiered system of privatised and commercialised healthcare delivery. Private provision has become increasingly widespread, while user fees and pharmaceutical charges finance a significant part of the public health sector¹.

This situation started with economic crises, the rise of unemployment and increase in demand. It was worsened with reorganisation of the health system in 1998. This was largely in the form of hospital reform. It brought about changes in hospital policy and rules, including the modes of financing and operation of public health facilities. They began to operate as semi-private institutions creating financial barriers for a large part of the Senegalese population, leading to inequality of accessibility.

Access to Public Health Establishments (PHEs) is a fundamental human right. And the right to health is recognised and protected by the Senegalese constitution and by international declarations, such as the African Charter of Human Rights. However, because of systemic weaknesses in hospital reform, access to health care remains unaffordable for the poor and rural populations. This leads to a sense of injustice.

The Senegalese state is responsible for poor health outcomes resulting from its reforms. Most of the population does not use formal health services when ill, because they lack the money to pay health expenses, even in public hospitals.



Dr. Mbaye Kamara, a pharmacist and health economist, is Secretary General of the C.H.N.E.A.R. (Albert Royer National Children's Hospital) of the SAT-Santé / CSA; member of the Federation of Independent Trade Unions (FSA) affiliated with the PSI.

For example, 68% of the poorest people cannot use maternal and child health services for economic reasons².

The government must therefore carry out systemic health care reforms which put the people at the heart of the reform process and thus facilitates improvement of the quality of health services for the entire population, including the most vulnerable groups, economically and socially. Such reforms must emerge from public discussions including the trade unions, civil society organisations and communities.

Shortly after his election in 2012, President Macky Sall promised to end inequitable access to health by 2022 by introducing a Universal Health Coverage (CMU) programme. The Strategic Plan for Developing Universal Health Coverage in Senegal 2013-2017 was designed to help achieve this goal³. But, the strategic plan has not been quite successful. Thus, less than three years to the set target, it seems unlikely that universal access will be achieved by 2022, except if drastic steps are taken now. The labour movement and particularly health unions in Senegal have a key role to play to ensure progress is actually made and not just rhetoric.

The roots of health inequities lie in social conditions outside the health system's direct control⁴. Therefore, there is need for renewed struggle against the precarious nature of the existence poor working people, in general. Related directly to the health sector, the unions have to call for improved funding of public health care and the de-marketisation of hospital services.

The UHC programme is a good opportunity to reduce social inequalities, but it must rest on the bedrock of availability of quality public health care for all, because health is a fundamental human right. Now more than ever, Senegalese trade unions must be at the forefront of campaigns for the realisation of this right, and for government to take concrete steps to address the social, economic and environmental determinants of health. □

1. Foley, Ellen E. "No money, no care: women and health sector reform in Senegal." *Urban Anthropology And Studies Of Cultural Systems And World Economic Development* 30, no. 1 (2001): 1-50
2. https://www.jica.go.jp/english/our_work/evaluation/oda_loan/economic_cooperation/c8h0vm000001rdjt-att/senegal_161115_01.pdf
3. <https://www.r4d.org/projects/laying-groundwork-universal-health-coverage-senegal-sustainable-financing/>
4. http://www.aho.afro.who.int/profiles_information/index.php/Senegal:Universal_coverage?lang=en

25 YEARS AFTER APARTHEID: HEALTH INEQUITIES PERSIST IN SOUTH AFRICA



Young workers at the PSI People's National Health Insurance Conference.

On 27 April 1994, history was made in South Africa. That day, now known as Freedom Day in the country, the apartheid regime was buried as South Africans voted in the first multi-racial elections in the country's history, marking a significant democratic transition.

In 1996, South Africa's final Constitution was enacted as one of the most socially inclusive and democratic in the world. Reflecting the spirit of the people's struggle that ended the regime of racial segregation, it included a Bill of Rights. In the constitution, it is explicitly stated that

"Everyone has the right of access to –

- 1. Health care services, including reproductive health care,*
- 2. Sufficient food and water, and*
- 3. Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance."*

This reflects a human rights-based approach to health which recognises the importance of social and economic determinants of health. Post-apartheid governments have made significant efforts to improve access to health care services over the last two and a half decades and progress has been made from the aftermath of apartheid.

But such progress remains inadequate. South Africa remains an "ailing nation" as Mark Heywood noted in an article¹ which draws attention to a "health crisis" rocking the country. He pointed out that:

- There are an estimated 300,000 cases of Tuberculosis and 80,000 TB-related deaths annually;

- 8,000 babies die each year during or shortly after birth due to preventable causes linked to health system failures;
- 30% of children are malnourished and obesity in adolescence and adulthood is prevalent due to paths of deprivation cut by childhood hunger;
- There is an exploding cancer epidemic, with people dying because cancer medicines cost so much and there are extremely few oncologists in the public health system;
- There are 270,000 new HIV infections and 89,000 AIDS-related deaths annually;
- There is pervasive corruption in the procurement of health equipment and medical supplies;
- Large numbers of publicly-

trained doctors and nurses are leaving the public health system – migrating or practicing in the private sector;

Heywood correctly noted that this worrisome state is symptomatic of the inequality inherited from South Africa's past. But at the same time, as he added, there is much that could have been done to improve the situation.

“Studies have shown that social inequalities in health is widening across social groups and races in South Africa as a result of the apartheid legacy”². For example, “(i)n 1987, the number of white dentists for each person in the white population was 1: 2 000, while for black people, it was 1: 2 000 000” and in 1990, the ratio of doctors to patients in (largely white-dominated) urban areas was 1: 900, but in the (black-dominated) rural areas it was 1: 4 100³.

But subsequent to the transition to a democratic South Africa, “macro-economic policies, fostering growth rather than redistribution, contributed to the persistence of economic disparities between races” and this has contributed significantly to the severe public health challenges which the country is confronted with today⁴.

Race remains an important social determinant of inequality, in what is probably the most unequal country in the world. Racialised social inequality in South Africa must however be understood along with sharp class divisions as an increasing number of black middle class and upper class now benefit from the system, in

industry, commerce and through neopatrimonial ties to the state⁵.


The dynamics of health inequities can thus be best grasped by understanding the disparity between the quality of care available to almost 50 million South Africans (with a large number in the rural areas) who can access health services only from the under-funded public health system, and the just over 8 million (mainly urbanised people) on “medical aid coverage” who can access well-resourced private sector health care delivery subsidized by the state.

For example, while one doctor sees 2,457 people⁶ in the public health facilities, the estimated ratio of doctors to people on the medical aid scheme is however 1 to 429. These divergent figures, scary enough as they are, are just the tip of the iceberg. The private health facilities have more up-to-date equipment, adequate medical supplies and are more conducive to delivering care.

South Africa might once again be on the cusp of history with the newly-drafted National Health Insurance (NHI).

PSI affiliates and civil society organisations are campaigning for a People's NHI⁷, unlinked from the Medical Aid Schemes. Publicly funded health must be for the people and not used to subsidise private insurance firms and health providers. Private healthcare has demonstrated its incompetence and how steeped in corruption it is, with R22 bn (US\$1.57m) lost to fraud and waste⁸ annually.

Rather, the NHI should serve as a pivotal instrument within a mix of government policies and programmes that strengthen the public health system, with active participation of the people.

This is an important step in rolling back the persistence of health inequities in South Africa. The next step is ensuring people over profit in fashioning out macroeconomic and social policies in general. The guarantee for lasting health equity lies in addressing the social, economic and environmental determinants of health. 

1. <https://www.spotlightnsp.co.za/2019/02/07/ailing-nation-the-things-so-na-wont-say-about-the-health-crisis/?fbclid=IwAR13ACdcsFefw55hQ2EoPGf7npQ-falB--nMImU0uinslXCSowPLC1IfT2qc>
2. Obuaku-Igwe, C. C. (2015). Health inequality in South Africa: a systematic review. *African Sociological Review/Revue Africaine de Sociologie*, 19(2), 96-131, pp: 98
3. Heywood, M. (2007). A background to health law and human rights in South Africa. *Health and Democracy: A Guide to Human Rights, Health Law and Policy in Post-apartheid South Africa*, 2-29, pp: 12
4. Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: historical roots of current public health challenges. *The Lancet*, 374(9692), 817-834.
5. Lodge, T. (2014). Neo-patrimonial politics in the ANC. *African Affairs*, 113(450), 1-23.
6. <http://www.hst.org.za/publications/South%20African%20Health%20Reviews/HST%20SAHR%202017%20Web%20Version.pdf#page=323>
7. <http://www.world-psi.org/en/fighting-peoples-national-health-insurance-south-africa>
8. <https://allafrica.com/stories/201903010069.html>

ASIA AND PACIFIC

KHMU CAMPAIGNS AGAINST FOR-PROFIT HOSPITALS

The Korean Health and Medical Union (KHMU) will organise a series of campaigns this year to defend the right to quality public healthcare and for workers' rights in the sector. At its 21st anniversary ceremony and regular congress¹ which took place on 27-28 February, the union decided to include all-out mobilisation against the expansion of for-profit hospitals and against precarious work.

In its mobilisation to stop the expansion of for-profit hospitals, KHMU intensified its struggle at the end of 2018. In Jeju Province, the provincial government had given permission for the construction of a for-profit hospital, the Jeju Greenland International Hospital. KHMU immediately set up a Taskforce Team against the hospital and held a 'Candlelight Cultural Performance against For-Profit Hospital in Jeju' on 15 December. The union also initiated a signature campaign against licensing Jeju Greenland International Hospital.

On 3 January 2019, a mass rally was held at the Jeju Provincial Government Building which urged Governor Won Hee-ryong of the Jeju province to retract approval for the for-profit hospital and step down as governor for putting profit over the welfare and well-being of

people. The demonstration included 280 union leaders from across the country and over 500 rank and file workers and civil society activists.

KHMU President Na Sun-ja said the union is "committed to preventing even a single for-profit hospital from opening". She added that protest against licensing of Greenland International Hospital "has since spread out nationwide, showing the reserved strength of the KHMU".

Health workers in Korea have fought against privatisation of health since 2014, when KHMU led three general strikes and collected around two million signatures in collaboration with civil society allies. The central government still went ahead to amend the medical service law, allowing for-profit



KHMU members protest against the for-profit hospital in Jeju. © KHMU

hospitals to be established. But KHMU won a partial victory, with the amended law allowing such private hospitals to be run only in free economic zones like the Jeju province.

Public hospitals represent only 10% of the entire medical institutions in the country. South Koreans want more public health coverage and not more for-profit health services, as demonstrated in Jeju. Governor Won organised a public opinion survey between March and October 2018 after the loud outcry against any attempt to grant an operating license to Greenland Jeju Healthcare Town Ltd.

The poll showed 58.9% of residents were against the for-profit venture in health. But Governor Won still issued the license, permitting the for-profit hospital to

be built on 5 December. Now, the union demands withdrawal of the plan and license for Greenland International Medical Centre and for it to become a public hospital. KHMU is committed to blocking the opening of more for-profit hospitals and for strengthening the public nature of medical services. This also requires improved staffing levels and decent work in public health facilities. Thus, the union is equally campaigning for enactment of a new Medical Personnel Law. It also wants to kick out precarious work, unpaid labour and all forms of violence (verbal or behavioural) at the workplace.

KHMU is not alone in this fight. According to President Na, the union works closely with the civil society movement taking the struggle “beyond Jeju to Seoul and to every corner of the nation”.

The action against marketisation and commodification of health is a democratic one. Unions must forge alliances with the civil society movement and communities. It is a struggle for a better future for all, with universal access to quality public healthcare.

Realisation of the right to health requires our unity and determination, as the KHMU shows. With these, victory is assured. ☐

1. <http://bogun.nodong.org/english/>

NEW LEGISLATION

UNIVERSAL HEALTHCARE

AND MATERNITY LEAVE

IN THE PHILIPPINES

Filipino President Rodrigo Duterte made history on 20 February 2019 when he signed several bills the government had enacted into law, including the Universal Health Care (UHC) Act and the Expanded Maternity Leave (EML) Act. Both are part of the PSI Philippines campaign under the Health Project supported by Finnish PSI affiliates and SASK.

THE UNIVERSAL HEALTH CARE ACT

According to the [World Health Organization](#):

“The new UHC Act is a critical step towards health for all Filipinos as it will facilitate major reforms to consolidate existing yet fragmented financial flows, increase the fiscal space for benefit delivery, improve the governance and performance of devolved local health systems, and institutionalize support mechanisms such as health technology assessment and health promotion”.

Speaking on this landmark development, the PSI General Secretary Rosa Pavanelli said:

“This success shows how international solidarity can really make a difference for public service workers and citizens. It is even more important as it contributes to ensure the fundamental right to health to the Philippines people. It is an achievement of the Filipinos and for the PSI global campaign on the human right to health.”

“Now we need to make sure that the enforcement of the new legislation does not turn into a gift for private insurance companies, nor create a double system, one for the poor and the other for rich people,” she added.

This requires adequate funding of publicly delivered health services to all, and enhanced participation of the people in the health policy process. The Philippines’ first step towards health for all was taken fifty years ago with the enactment of the Philippine Medical Care Act. And in 1995, the National Health Insurance Act was passed, setting up the Philippine Health Insurance Corporation (PhilHealth). It had the aim of implementing universal health coverage.

The impact of the earlier legislation was undermined by inequities in access to health services and health status. Instead of health being free for at point of delivery for all, citizens considered to be indigent were merely subsidised. They still had to make out of pocket



PSI affiliates in the Philippines campaigned intensely in favour of the new laws.

payments (which they could hardly afford) to access care in private health facilities. Due to this, poor communities have suffered a higher burden of disease, despite PhilHealth's claim of achieving "universal" health coverage for 86% of the population in 2010.

The new UHC Act opens additional sources of funding for PhilHealth, through taxes, which will enable universal access to free diagnostic services, consultation fees and medical tests.

As the Philippine Department of Health (DOH) and PhilHealth draft the implementing rules and regulations (IRR) for the Act, we assure them of our support and urge them to ensure quality health for all remains the cornerstone of this historic legislation.

THE EXPANDED MATERNITY LEAVE ACT

The Expanded Maternity Leave Act is equally a very progressive legislation. It was first approved in the Senate two years ago. It has extended paid maternity leave from 60 days to 105 days. Seven of these 105 days are transferable to the father, at the discretion of the female worker entitled to maternity leave benefits. There is also an option of extending the leave by 30 more days without pay. And employees who are single parents will enjoy 15 additional days of fully paid maternity leave.

The law further ensures that maternity leave shall be granted to female workers in every instance of pregnancy or miscarriage regardless of frequency.

Implementation of the EML will go a long way in promoting women's rights as human rights in the world of work, as well as improving maternal and child health outcomes. Gender equality is an important part of PSI's work, so we welcome the new law.

We share the view of Senator Risa Hontiveros, a friend of PSI who has been at the fore of advocacy for the passage of the bill over the last few years, that:

"The signing into law of the Expanded Maternity Leave Act is a moment mothers, families, and children will not only remember, but a victory generations of Filipinos will reap the benefits of for the rest of their lives." ☐

The Community Health Workers programme in Pakistan, commonly known as Lady Health Workers, LHWs programme, was started in 1994 with a staff of nearly 30,000 women. Over the years, the programme has expanded to more than 125,000 employees deployed in all districts of the country. They serve as the cadre that links first-level care facilities to communities.

COMMUNITY HEALTH WORKERS IN PAKISTAN – A STRUGGLE FOR UNION REGISTRATION

by Mir Zulfiqar Ali, Executive Director of Workers' Education and Research Organisation (WERO), based in Karachi, Pakistan

The programme's objective is to provide essential primary maternal, neonatal and child healthcare services, family planning, and integrating health promotion programmes. Almost 60 percent of Pakistan's population is covered by the programme. It was cited as a game changer in the country as it played a key role in improving health outcomes in rural areas. It also revitalised the public healthcare system and reduced the gendered division of public and private spaces, which has been a major obstacle in women's access to basic services including education and employment. The programme is one of the few non-agricultural, formal sector employment opportunities for women in rural areas.

However, despite these achievements, LHWs face many challenges. Initially not considered employees of the public health care system, they were not entitled to wages and labour rights.

Faced with extremely poor working conditions without wages, long hours, no clear job description, uncertainty of tenure and lack of safety while on the field or any legal rights recognised by the state, LHWs formed an association

in 2009, the All Pakistan Lady Health Workers Association (APLHWA). They started a national movement for the regularisation of their jobs as public servants. They organised protest rallies, press conferences, sit-ins and nationwide media campaigns, and filed a petition in the Supreme Court of Pakistan. In 2012, when APLHWA organised a large protest in front of the Supreme Court of Pakistan with the participation of LHWs from all over the country, the Chief Justice of Pakistan ordered the regularisation of all staff under the programme, namely LHWs, Lady Health Supervisors (LHSs), drivers, account supervisors and programme management unit staff.

However, because of a series of administrative delays it took more than four years for the regularisation to be adopted by each of the four provinces of Pakistan.

Since then, LHWs continue to face many issues, especially concerning payment of their wages. There are delays, arrears are not paid, fuel and vehicle maintenance allowance are denied, and salaries do not correspond with seniority and qualifications. Other issues include the lack of service structure, sexual harassment, lack

of proper security during polio vaccination campaigns, denial of maternity leave and broken-down medical facilities.

Considering the denial of LHWs' legal rights in the Province of Sindh, they organised themselves as the All Sindh Lady Health Workers Association (ASLHWA) in 2013, with the aim of collectively fighting for the rights of LHWs in Sindh. ASLHWA fights against injustice and unites around 25,000 workers and employees of the Lady Health Workers' Programme.

In 2016, with the support of PSI and the Workers' Education and Research Organisation (WERO), a labour support group, ASLHWA launched a Campaign against Stolen Wages to highlight the impacts of delayed wages and demand fair remuneration and decent working conditions for LHWs.

ASLHWA organised district-level meetings to strengthen the union through increasing outreach, lobby meetings to engage government officials, parliamentarians and leadership of mainstream political parties. It organised conventions and conducted research on key issues.

After three years of campaigning, the union successfully resolved some major issues on payment of wages. Regularization letters were issued to LHWs, wage costs of LHWs were included in the budget proposal of 2017 and the union made sure the requirements for bio-metric verification of employees at districts level complied with. These actions were led to the payment of wages directly to the workers through the treasury. In addition, ASLHEWA successfully campaigned for the payment of arrears and payment of pending fuel and maintenance dues.

STRUGGLE FOR THE REGISTRATION OF ASLHWEU

Despite these extraordinary achievements, ASLHEWA was not an officially registered trade union.

The process to register All Sindh Lady Health Workers and Employees Union (ASLHWEU) started in April 2017, when the union submitted documents to the registration authority. Under article 9 of the Sindh Industrial Relations Act (SIRA) 2013, the registrar is bound to issue the registration certificate within 15 days after submission of the application. However, the application went through several administrative delays.

In July 2018, with help from PSI, the union developed a three-stage strategy to pressurize the government for registration. They decided that this would include educating the membership on the importance of union registration and holding protests in front of labour departments of different regions in Sindh. They also agreed to lobby parliamentarians and political parties, with support from like-minded senior trade unionists, lawyers and civil society organisations as well as with international labour organisations.

In the 1st stage, ASLHWEU mobilised its membership at the district level to prepare them for street protests against the labour

department. The union held fifteen meetings to mobilise members on district and tehsil (local) levels across the Sindh and organised two demonstrations in front of labour departments of Hyderabad and Sukkur. At a sit-in in the city of Hyderabad, around 3000 LHWs blocked the roads for two hours, chanting slogans against the labour department. These actions were widely covered by the media.

In the 2nd stage, ASLHWEU leadership along with members and other trade unionists, met with the labour director to demand approval of the union's application for registration. They also warned him that more than 24,000 members would be on the streets if their demand was not met. He was further informed that the matter would be taken up with the ILO Committee for Freedom of Association.

In the 3rd stage ASLHWEU organised lobby meetings with the newly appointed health minister and women Members of Parliament to draw their attention to the violation of the constitutional right of LHWs

by the labour department. The MPs assured that the issue would be taken up at parliament and raised in party meetings.

In the meantime, ASLHWEU also met with the legal advisor of the labour department and provided him with relevant jurisprudence regarding the formation of unions by government servants. The legal advisor confirmed that LHWs are entitled to form a union. After almost two years of struggle, the labour department confirmed the registration of ASLHWEU in October 2018. Since ASLHWEU is the sole registered union of LHWs, it is now applying for a 'collective bargaining agent' certificate.

ASLHWEU organised a convention in Hyderabad on 28 December 2018 to celebrate this big win and invited its allies to thank them for their unconditional support to win the right of association for LHWs. Special thanks were given to PSI and WERO for their full support at all stages and in anticipation of their support in the future. □



*Samina, one of Pakistan's Lady Health Workers.
©Jamshyd Masud*

Every year, around 55 million Indians are pushed into poverty due to catastrophic healthcare expenditures. And this is only one of the symptoms of a broken system that is also entrenched in ethical issues over inappropriate treatment in private facilities, overcrowded and underfunded public facilities and deteriorating work conditions.

2019 INDIA

FEDERAL BUDGET PUSHES

PRIVATE INSURANCE IN HEALTH

*by Susana Barria, PSI Trade Justice Campaigner
in the South Asia sub-region*

In the last issue of Right to Health, we published a critique of the Indian Governments proposed ‘Modicare’ health insurance scheme, raising concerns about its adequacy in resolving the issues people in India face in accessing healthcare.

As India prepares federal elections in May 2019, the current government presented its last budget in January. What emerges from the Interim Budget 2019-2020 is the consolidation of two trends – allowing public health services to collapse, while strengthening the role of the private sector through one of the world’s largest public-private partnerships in healthcare.

THE INTERIM BUDGET IS BIASED AGAINST STRENGTHENING PUBLIC HEALTH SERVICES

In the budget, government systematically neglected components that are essential to strengthening public healthcare. For instance, capital expenditure used to build infrastructure and procure equipment has been reduced by 43% in the interim budget 2019-20 over the actual expenditure in 2017-18. Resources towards establishing new medical colleges and upgrading district hospitals have declined by nearly 40% over the expenditure in 2017-18. Schemes to strengthen district



Enrolling for National Health Insurance in India. ©ILO

hospitals and medical colleges with more human resources face reduction in real terms too. As for the frontline workers, the budget speech offers a risible increase in the honorarium of community health workers (known as accredited social health activists or ASHAs) from the current INR 2,000 per month to INR 3,000 (US\$ 28 to 42), which is far less than the long-standing demand for a monthly wage of INR 18,000 (US\$ 253) (JSA Statement).

The National Health Mission (NHM) launched in 2005 had increased budgetary allocation to public primary care facilities especially in rural areas. It is under this programme that the network of

Primary Healthcare Centres (PHCs) was strengthened. This led to an improvement of health outcomes by bringing people back to public sector facilities in rural India. However, the budget allocation for NHM is lower than the expenditure of the previous year. The share of NHM in the total allocation on health has gone down from 61% in 2014–15 to 49% in the 2019–20 budget.

Yet, the overall health budget has seen an increase, more than half of which is dedicated to a single scheme, the insurance component of the Ayushman Bharat Scheme. The Ministry of Health and Family Welfare (MOHFW) has received an allocation of INR 633 billion (US\$

8.8 billion), an increase of INR 70 billion compared to the previous year. INR 64 billion is devoted to the Pradhan Mantri Jan Aarogya Yojana (PMJAY), with an impressive 167% increase over the previous year.

WHAT IS THE AYUSHMAN BHARAT SCHEME?

The **Ayushman Bharat Scheme** is a national health initiative that was announced in early 2018, with two components. The National Health Protection Mission or Pradhan Mantri Jan Aarogya Yojana (PMJAY) is the insurance scheme for hospitalisation in empanelled private or public hospitals. PMJAY is expected to cover around 100 million families (close to 40%

of Indian population) when fully operationalised.

This is an expansion of an existing scheme called RSBY, under which India's poorer families were insured by the government to the tune of INR 150,000 (US\$ 2,100). Under PMJAY the insurance coverage is increased from INR 150,000 to 500,000. The second component is the expansion of existing sub health centres, under the name of Health and Wellness Centres (HWC) to provide free primary care in rural areas.

PMJAY: SINKING PUBLIC RESOURCES FOR PRIVATE PROFITS?

While PMJAY has received the highest increase in this budget and represents close to 10% of the total MOHFW budget, the allocation remains highly inadequate for what it proposes to do. The current allocation (INR 64 billion) is lower than the government's planning body Niti Ayog's own calculations that at least INR 100 billion is required, just to pay premiums.

Yet, health economist **Indranil Mukhopadhyay** shows that even this calculation corresponds to a grossly underestimated premium payment of INR 250 per person per year. This would be largely insufficient to ensure adequate hospital treatment of the covered population. He suggests that the numbers should be in the range of an allocation of above INR 600 billion to be adequate – a figure closer to the total health budget of the MOHFW.

This points to the inadequacy of the health budget, which stands at around 1% of GDP (union and state budgets combined), instead of the long-standing promise of 2.5% of

GDP or the WHO recommended 5% of GDP.

Private players have welcomed the move towards a consolidation of insurance-based health provision and are also proposing their own estimates. Private providers are demanding that the allocation for PMJAY be **increased to INR 2,500-3,000 billion** if the government wants it to be sustainable for the private sector to be meaningfully involved. This would mean that while the government does multiply its budget from the current 1% of GDP to the recommended 5% of GDP, it fully sinks public funding for healthcare into mostly private provided hospitalisation for 40% of the population through PMJAY, with little resources for primary care provision. Further this would also mean that 60% of the population will either have to pay on their own for healthcare services in the private sector, or rely on a further neglected public health system.


FLAWED PUBLIC-PRIVATE PARTNERSHIPS IN HEALTHCARE

Experiments with the earlier avatar of PMJAY, the RSBY, have shown that where the public healthcare sector is weak, the scheme gives a boost to the private sector. Data from 2016 shows that 80% of reimbursements under the scheme were made to **private enterprises**, though in smaller hospitals. Big players in healthcare hospitals (the so called luxury hospital sector) have welcome the increase coverage as 40% of India's population would become potential buyers of the treatment rates they offer.

PMJAY essentially incentivises private investment in healthcare,

not only through this assured market share, but with subsidies as well, such as facilitated access to land and viability gap funding, as was announced in a [recent press release](#).

Not surprisingly, the government push for PMJAY has been criticised by health networks such as Jan Swasthya Abhiyan (JSA). "The Interim Union Budget 2019-20 reflects a definite push for an insurance-based model of healthcare, which comes at huge and disastrous costs of the public provisioning of health. [...] When insurance is scaled up in a context where there is a huge inadequacy and inequity in access, and an almost complete absence of regulation, it would result largely in the transfer of public funds into private hands without any matching health outcomes or financial protection."

The Statement published by the nation-wide health coalition which is affiliated to the People's Health Movement (PHM) calls on the government to strengthen public provisioning of healthcare, ensure adequate supply of free medicines and diagnostics, work towards upgrading of primary health centres and community health centres, improve working conditions of the health workforce and ensure community accountability of public health services. Unions of health workers in particular, and public services workers in general will be an essential ally in exposing the impacts of the current flawed direction of health policy. Clearly, with this budget, the challenge for a just and equitable health system with quality public provision of healthcare at its core has gotten harder for the right to health movement. 

EUROPE

EPSU 50th Standing Committee ON HEALTH AND SOCIAL SERVICES



*Jan Willem Goudriaan,
General Secretary, EPSU*

The European Federation of Public Service Unions Standing Committee on Health and Social Services (EPSU SC HSS) held its 50th statutory meeting on 27 February at the International Trade Union House, Brussels. Speaking during the course of the meeting, the EPSU General Secretary, Jan Willem Goudriaan noted that this marks a milestone in the history of EPSU.

The EPSU SC HSS meets twice a year to deliberate on issues of concern to health and social sector unions across Europe. It also serves to promote social dialogue within the European Union mechanism and with the European Hospital and Healthcare Employers' Association (HOSPEEM).

The meeting deliberated on a wide range of issues, including items of sectoral social dialogue in the hospital sector such as joint priorities and action points for EPSU in the field of musculoskeletal disorders (MSD) and psychosocial risks and stress at work (PSRS@W). Concepts and reforms concerning skills mixes and task shifting were also discussed. And affiliates shared information on initiatives to address the impacts of digitalisation in health and social care, in line with an ongoing


collaboration between EPSU and the European Trade Union Institute (ETUI).

With the EPSU Congress coming up on 4-7 June at Dublin, updates on the draft Programme of Action and congress preparation was an important item on the agenda. The first exchange on thematic priorities for the health and social services sector for 2019-2024 was a first step to formulate the Standing Committee's Work Programme for the next five-year period.

Exchanging information on staffing levels and taking action to ensure safe and effective staffing for health will be an important part of the work in the coming period, according to the EPSU Policy Officer for the sector, Mathias Maucher. A web portal will be established as a repository of good practice.

Baba Aye, the PSI Health and Social Sector Officer updated the Steering Committee on implementation of the PSI Programme of Action 2018-2022 in the sector and recent HSS-related activities in general.

He spoke on engagement with the Global Skills Partnership (GSP) in relation to international health worker migration, the PSI Right to Health global campaign; proposed research work for 2019, and enhancing participation of affiliates in World Health Organization and OECD Health Committee meetings. He also urged more European affiliates to contribute articles to the PSI Right to Health Quarterly.

The meeting ended in high spirits, with 8 October fixed as the date for the next meeting of the Steering Committee. 

UNISON will ensure
that the voice of
healthcare staff is
heard in the way the
Plan is implemented.
©Number 10



THE LONG TERM PLAN FOR THE NHS IN ENGLAND

by Guy Collis, health policy officer of UNISON

The UK National Health Service has just published its latest plan for how the NHS in England should be organised over the next five years and beyond.

The 136-page document¹ represents a vision of a future health service that is based more on treating patients outside of hospitals, with a larger role for new digital technology and, in theory at least, a much smaller role for market competition. Overall, the plan represents a mixed bag of laudable intentions and daunting challenges for a system that remains beset by financial problems and a staffing crisis.

From a trade union point of view, there are some clear positives, including the potential for legislative change to remove the worst elements of the NHS market in England that were established by the abhorrent **Health and Social Care Act of 2012**².

It should, however, be noted that such plans are only suggestions from the NHS itself rather than clear commitments from government. It remains to be seen how realistic it is to expect politicians to push

through legislation at this time, given that the UK Parliament remains deeply divided and dominated by Brexit.

Another positive aspect of the report is a focus on improving mental health services and an understanding of the need to halt the fragmentation of England's ambulance and emergency services.

But there are less positive aspects too, such as the continuing desire to drag yet more "efficiency savings" from administrative budgets, despite the fact that most hospitals have already been cut to the bone.

And, as waiting times for treatment continue to grow, there is a renewed drive to offer private sector treatment to patients if they have been waiting too long for care.

Perhaps most important of all, however, is what is missing from the Plan, most tellingly the relatively meagre commitments for the workforce.

An accompanying strategy for the future health and care workforce has still not surfaced and until it

does, it remains hard to see how the NHS will be able to implement many of the worthwhile ambitions contained within the Plan.

Beyond this, the continued failure by the government to publish its proposals for social care, along with ongoing cuts to public health services, threaten to undermine the goal of a more cohesive health and care service for England.

There is of course further uncertainty stemming from the UK's impending exit from the European Union and the lingering fear that the extra funding the government has committed to the NHS, while welcome, will only be enough to keep services from collapsing rather than allowing the system to make the much-needed improvements.

UNISON will be working hard in the coming months to keep up the pressure for a meaningful workforce strategy and to ensure that the voice of healthcare staff is heard in the way the Plan is implemented. □

1. <https://www.longtermplan.nhs.uk/>
2. <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

FRANCE

LET'S TALK ABOUT STAFFING AGAIN



The survey on staffing involves paramedics and healthcare staff in France. ©Gaetan Zarforoushan

by Eve Rescanières

The French union CFDT Santé Sociaux (health and social services) decided to continue with the survey on staffing for paramedics and healthcare staff it initiated in 2017. This annual barometer is part of the roadmap that our federation has set itself in terms of investment in European bodies and international trade union involvement.

The initiative is connected to CFDT's work with the European Federation of Public Service Union (EPSU). In Brussels, a question of concern to the various European unions in the health and social sector is; should we advocate for minimum staffing level legislation?

We think that the important thing is not to provide a ready-made and definitive answer, but to ask the right questions, and to ask the main stakeholders.

Thus, our questionnaire, which employees had access to between 25 June and 1 July 2018, is the same as in 2017. And as in September 2017, the respondents spoke of conflicts of workplace values that go against their professional ethics. Dissatisfaction with poorly

done work is the predominant factor.

As in September 2017, employee testimonials add a personal touch to the statistics, diagrams and percentages, which are certainly essential to build a database to present an opposing motion to the employers, but not sufficient on their own.

"What is important is not the number of patients, but the needs of each patient" is the response of employees when asked for their opinion on good practice.

To be able to act and have influence in European dialogue, CFDT Santé Sociaux thinks it is vital to reconnect with the workplace.


Slowly but surely, our method is proving effective. On issues as diverse as activity and skills benchmark and the competence of care assistants, or the setting up of territorial social dialogue conferences, our main concern is those who do, not those who give the orders to do. And sometimes, management ends up adopting what we have built with the employees.

It is with this mindset that we wanted to give space to non-academic feedback to build our investigation.

Once upon a time there was the aging of the European population. Once upon a time, there was budgetary discipline with its share of deregulation, flexibility and precariousness for employees.

Once upon a time, there was a network of European health and social services unions, pioneers of social justice.

And in this network, once upon a time, the CFDT Santé Sociaux was and still eager to contribute to building a social Europe which guarantees high protection for workers in the health, social and medico-social sector.

To do this, we are giving you an appointment in September 2019 to continue to refine our vision of the working conditions of healthcare professionals and paramedics through the prism of the workforce. 

BULGARIAN FEDERATION OF TRADE UNIONS

HEALTH SERVICES

CONTINUES TO DEFEND

WORKERS AND PUBLIC HEALTH

*Ivan Kokalov,
President of
Federation of
Trade Unions –
Health Services,
Bulgaria.*



The Federation of Trade Unions – Health Services (FTU-HS-CITUB) was founded 30 years ago and is Bulgaria's largest trade union federation in the healthcare sector. Throughout its existence, the federation has successfully overcome many challenges and has become an active partner whose voice is heard by governments, employers and NGOs alike. FTU-HS continues to defend the social and labour rights and interests of all healthcare sector employees – be they medical specialists (doctors, nurses, midwives) or administrative and assistance personnel. The federation works with regional councils around the country to ensure health sector workers all over Bulgaria benefit from labour protection, guarantees on the right to work, decent wages and better quality of life and social status.

The first collective bargaining agreement was signed in 1991 after FTU-HS-CITUB helped develop the collective bargaining process in

the Bulgarian health sector. Since then, the federation has continued to consistently promote the cause of workers in the health sector, with adroit use of the collective bargaining mechanism.

Its most recent collective bargaining agreement (CBA) was in 2018. This included an increase of 45-50% for initial salaries in the medical sector (1,500BGN for doctors, 950BGN for nurses*), together with occupational health and safety provisions, specific social acquisitions and qualification brackets, with the aim of providing a better sense of security at work, leading to better quality healthcare.

The CBA also includes provisions for preventing all forms of discrimination and of physical or psycho-social violence in the workplace and as well guarantees in the working conditions to prevent chronic stress and physical or psychological injuries at work.

Bulgarian Federation of Health Workers organised a joint protest in 2018 with the Nurses' Association against nurses' low wages, their working conditions, increasing migration of nurses and the consequent lack of qualified nurses in hospitals, all of which have a detrimental effect on the quality of health services. The action was successful and resulted in the signature of new collective bargaining agreements and wage rises.




The federation has applied the collective bargaining agreement as a principal tool to defend healthcare workers' interests and labour rights when faced with difficult and controversial healthcare reform. Over the years, FTU-HS has constantly insisted on the need for reform in the healthcare sector and for noticeable improvements in public healthcare provision in Bulgaria. As an active member of the sectoral legislative committee in Parliament, the federation frequently introduces initiatives and amendments.

However, the ongoing healthcare reform in Bulgaria, especially when compared with development trends of healthcare systems

in Western Europe, makes health workers wonder if the government aims to align the Bulgarian health service with countries with well-functioning healthcare systems or whether it is following the dictates of a "global market in social services".

Answering that question poses a serious challenge to Bulgarian society as a whole and to the political class in particular. Despite the complex political and financial environment in the healthcare sector, FTU-HS-CITUB strives to preserve the moral dignity of the medical profession and to foster trust in the health workers' daily battle against disease.

It is the Bulgarian State - and not the patient - that ought to be indebted to the medical professionals. We must, therefore, demand rules and conditions of government that are designed to retain our medical specialists here in the country. Through their active work, FTU-HS and its members provide a counterpart to market pressures in the name of solidarity and the health and well-being of the Bulgarian people.

* Note: 1 BGN = 1,955 EUR 

INTER-AMERICAS

CANADIAN UNIONS

CAMPAIGN FOR UNIVERSAL

ACCESS TO PRESCRIPTION DRUGS

According to the [Wellesley Institute](#)¹, Canada is the only developed country with a universal healthcare programme which does not include access to prescription drugs. Thus, while Canadians don't need to pay to see their doctor, prescription drugs are not covered by the universal healthcare programme. And they are some of the highest priced in the world, with patients' out-of-pocket expenditure on prescribed drugs amounting to \$3.6bn annually.

Big pharmaceutical corporations make huge profits from the marketization of prescription drugs. And they have great policy influence on the federal and provincial governments. The National Union of Public and Government Employees (NUPGE) observed that "for large insurance companies or drug manufacturers, [the current situation is very profitable](#). They would prefer not to see a national pharmacare programme."²

Similarly, Linda Silas, CFNU president said, "big pharma and the insurance industry profit from our current system, and Canadians don't trust them to look out for our interests or think they should influence our public health care policy".

The costs of this overbearing influence of big pharma is not only in dollars and cents. It includes the loss of lives and has adverse impact on people's wellbeing. [An expert research report](#)³ commissioned by Canada's nurses last year found that at least 640 people die prematurely every year from one disease alone because of unaffordable medications. It also documented the avoidable deterioration of the health status of some 70,000 older Canadians annually due to the high cost of medications.

A national poll commissioned by the Canadian Federation of Nurses Unions (CFNU) and conducted by Environics Research between 9 and 21 January reveals that Canadians want universal pharmacare. This was stated in a [media release](#)⁴ issued by CFNU on 19 February.

The poll confirmed that:

- 88% agree it is better to have a simple cost-effective prescription drug coverage program that covers everyone in the country than the existing patchwork programme.
- 85% agree that it is worth investing public money for prescription drug coverage.
- 84% think that prescription drugs should be included in our public health care system.

Lack of universal access to prescription medications has increasingly undermined the benefits of Canada's universal healthcare programme. In an article published in the [Canadian Medical Association Journal](#)⁵ in 2012, Michael R. Law et al showed a 10% cost-related non-adherence to prescription in the population.

By 2015, members of almost one in four families were not adhering to prescriptions because they could not afford the price of medication, according to a [national poll](#)⁶.

An additional 36% of Canadians responded that pharmaceutical expenditures were causing them financial hardship. 91% of respondents declared support for a national pharmacare programme that would ensure universal access.

CFNU organised an [issue-based campaign](#) to place healthcare issues at the front burner of debates during the 2015 elections; [#Vote4Care](#)⁷. The campaign called for expanding medicare into new areas, including pharmacare. Public concern on the need for a national pharmacare programme which puts people over profit heightened after the elections.

For over a year, the federal health committee heard from more than



©: Government of Prince Edward Island

100 experts after which it⁸ called for the expansion of the Canadian Health Act (CHA) to include pharmacare in April 2018. Two months later, Prime Minister Justin Trudeau constituted a seven-member national advisory council led by Dr Eric Hoskins, former Ontario health minister, to come up with a national pharmacare strategy.

In September, **more than 70⁹** national, provincial and territorial organisations, including NUPGE and CFNU, came up with the best model for national pharmacare, as part of the policy formulation process, national dialogue initiated with the constitution of the advisory council.

This is based on **Consensus Principles for National Pharmacare¹⁰**, which has now been adopted by over 80 organisations, viz:

- Universality
- Public, Single-Payer Administration
- Accessibility
- Comprehensiveness
- Portable Coverage

These principles constitute the backbone of the 28 September 2018 submissions of **CFNU¹¹** and the **Health Sciences Association**

of British Columbia/NUPGE¹² to the Advisory Council on the Implementation of National Pharmacare. The submissions stressed the need for Canada's national pharmacare to be "governed by a public authority on a non-profit basis to ensure accountability exclusively to the public interest and democratic institutions". The final report of the advisory council will be released in June. However, an **interim report¹³** was issued at the beginning of March. While presenting the report, Dr Hoskins said "the current system of prescription drug coverage in Canada is inadequate, unsustainable and leaves too many Canadians behind". His council has called for the establishment of a national drug agency to address the issue.

The interim report fails to address a **universal, single-payer pharmacare¹⁴** programme. But, as Larry Brown, NUPGE President points out, it "**clearly states the urgent need for national pharmacare¹⁵**". The campaigns of the labour movement and civil society organisations in Canada has thus yielded fruit.

A united front¹⁶ of trade unions and civil society organisations in Quebec has demanded the implementation of a national public,

universal pharmacare plan. There are lessons to be learnt from the experience of the province since the introduction of an **insurance-based drug coverage in 1997¹⁷**.

The most important of these, as Fédération Interprofessionnelle de La Santé du Québec has consistently pointed out, is that such public-private systems of insurance **do not work¹⁸** and 100% public pharmacare programme is necessary.

Activists across Canada will thus continue to campaign for universal access to prescription drugs as an essential element of the struggle for full realisation of the right to health. This includes urging the advisory council to include a recommendation for national pharmacare to be governed by the principles of the Canada Health Act (CHA) in its final report. □

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CHILE

FENPRUSS UPDATES ITS

“ANOTHER HEALTH SYSTEM

IS POSSIBLE” PROPOSALS

The National Confederation of Health Service Professionals (FENPRUSS) has enthusiastically begun work on updating its proposals for strengthening and defending the public health system in Chile. This important work is taking place with the valuable support of Matías Goyenechea and his team from the [Creando Salud Foundation](#)¹, who will be calling on a range of academics to contribute ideas on the four components that we hope will complement the work that has already been completed by the organisation.

This work will build on material included in the document [La Reforma del Bicentenario de la Fenpruss](#)² and the booklet [La Salud que Soñamos es Posible](#)³ (Another health system is possible) and will deal with issues

such as the constitutional right to health, strengthening the public health system and its operation, funding and human resources.

“We have decided to take this important step because we must contribute to the discussion on the health reforms that Chile needs. We already know a lot about the situation and this task represents one of our union’s key areas of work. We have pressed for a bigger and better public health system. We have defended the system through our proposals, ideas and actions in the street in the 23 years since FENPRUSS was founded”, said Aldo Santibáñez, national president of FENPRUSS.

Santibáñez explained that the results will be validated in the same way as before, that is, at a national

meeting, so that the final document produced with the help of contributions by academics and specialists on the issue of health can reflect the thoughts of all FENPRUSS members.

Matías Goyenechea, adviser to the union, said that the work aims to be participatory and to contribute to the discussion on health reform in the country. He said that it builds on work already done by FENPRUSS in its booklet *Salud que Soñamos es Posible*. “We want to analyse the difficulties and inequalities in the system and we hope we can achieve this by updating the union’s proposals for the health system”. □

1. <http://creandosalud.org/>
2. [FENPRUSS Bicentenary Reform](#)
3. [Another Health System Is Possible](#)

“We want it to be a participatory process that takes on board the aspirations of all those who believe in a strong and high-quality public health system able to make progress towards providing timely and supportive health care for all Chileans”, said the FENPRUSS national president.



FENPRUSS members display the booklet “Another Health System is Possible.” Photo: FENPRUSS

Thanks to the generations trained in the middle of the 20th century, Chile has played a leadership role in the field of public health. Despite the brutal reverses inflicted by the dictatorship, it has health indicators that place it in the vanguard in Latin America and the world. For example, life expectancy is longer than in the United States, even though there are less resources. This success has been built on the commitment of health professionals. Comparing Chile with other OECD countries, the country has 2 hospital beds per 1,000 inhabitants (OECD average is 4.9); 3.2 medical appointments (OECD average 6.4); and 9,936 hospital discharges (OECD average 15,508). This clearly shows that Chile allocates less resources to health, as does data showing health expenditure per inhabitant: health expenditure in the United States is US\$ 8,233 per year per inhabitant, the OECD average is US\$ 3,265 and Chile is US\$ 1,202, including both the public and private sectors.

The situation is even more dramatic if we take into account that the average figure of US\$ 1,202 per person disguises the fact that the public health system provides healthcare for most of that part of the population that has a smaller percentage of income. In this context, FENPRUSS will steadfastly continue to defend the public health system and oppose the growing transfer of resources to the private sector, whether that takes place through granting hospital concessions or the procurement of services. FENPRUSS will continue to campaign for decent work and quality jobs, denounce the shortfall in human resources, demand training and adequate working conditions and reject any abuses, in the knowledge that the ultimate aim is to deliver quality health care to service users.

COSTA RICA :

GOVERNMENT THREAT

TO THE RIGHT TO STRIKE

By María Esther Hernández Solís

The National Association of Nursing Professionals (ANPE)¹ in Chile is fighting new legislation which aims to abolish the right to strike. The action started when the union exposed that big business was receiving fiscal advantages while public services struggle. Now they are fighting against four bills removing the right to strike.

A bill on “Legal Security Regarding Strikes and Associated Procedures” is before the Costa Rican legislative assembly. The government aims to abolish the right to strike, if it is passed into law. The bill is backed by a president who has demonstrated his contempt for the people and a legislative assembly ready to remove hard-won labour rights, including the right to protest.

The background is a strike that began on 10 September and lasted 90 days. The strike was called against government proposals for fiscal consolidation and reducing the fiscal deficit. The only ones to lose out were public service workers, while big companies continue to evade and avoid their responsibility to pay tax.

This bias towards big business was unmasked when the Constitutional

Court forced the finance ministry to present a list of companies that submitted tax returns indicating zero profit and therefore no tax liability.

The list was made public and showed that one in four big companies claimed zero profit even though these companies had a turnover of **8.1 billion colons**² during the period of 2010-2016 and their assets were valued at **15.5 billion colons**³.

It was equally alarming to find out that, in the period 2010-2014, the tax authorities did not examine the accounts of 76% of the big companies that declared net losses in two or more consecutive financial years. Despite these figures, the government is threatening the pay and working conditions of public service workers, who have their taxes deducted at source and thus no tax liabilities.



Rodrigo López and María Esther Hernández Solís, ANPE.
©Aaron Sequeira.

María Esther Hernández Solís is a leading member of the National Association of Nursing Professionals (ANPE)

In the current legislative session, four bills under consideration all argue that protests should not affect the general public and all of them remove the right to strike. The bills arbitrarily classify a range of services as essential and are drafted in such a way as to make workers afraid to go on strike. They even go so far as to threaten the dissolution of individual unions.

Our union was called on to respond at the legislative assembly's Economic Affairs Committee. Dr Rodrigo López García, our general secretary, and Dr Ma. Esther Hernández Solís, a member of our executive committee, emphatically expressed their opposition:


"We do not agree with this bill.

It removes the right to strike, which is a basic right for workers who feel under threat at any particular moment. It is

contrary to the country's constitution and violates international instruments. It goes against decisions made by the Committee on Freedom of Association and the Committee of Experts on the Application of Conventions and Recommendations. It is therefore a regressive measure.

As for what is an essential public service, the authorities should specify what exactly is essential about the services in question and define the concept in relation to those particular services. The CCSS⁴ provides an essential service but it is the administration's negligence and not strikes that have paralysed the provision of specialist services, causing delays in operations and long waiting lists and forcing insured parties to make claims against the institution on the grounds

of negligence. Workers have taken action on behalf of patients rather than to win benefits for themselves."

The government should respect the social dialogue mechanism and promote decent work to curtail industrial conflict instead of resorting to strategies that undermine workers and trade union rights, even if this is with laws. Such a law, if passed, is unjust. Our union is therefore ready to defend public service workers' right to strike, including health workers in Costa Rica. 

1. <http://anpe.co.cr/>
2. 13,900.000\$US
3. 25,240.000\$US
4. Costa Rican Social Security Fund.

ARGENTINA:

30,000 HEALTH

PROFESSIONALS

STRIKE



The Trade Union Federation of Health Professionals of Argentina (FeSPoS) organised a two-day strike on 6-7 March “against adjustment and dismissals”. Nearly 30,000 doctors, nurses, pharmacists and other professionals downed tools in over 600 health facilities across the country.

In a press statement, the union said, “We are committed to fighting for dignified health for the most vulnerable sectors of society, a fight that goes hand in hand with decent wages and infrastructure conditions.”

The government’s refusal to enter a collective bargaining agreement that would improve working conditions for health and social workers is only part of its renewed attacks on working conditions and the labour movement. And to rub salt on an open wound, the government dismissed workers at the largest health facility in the country, the Posadas Hospital in Buenos Aires. This is in line with its programme of **downsizing the public sector workforce**, since 2016. **Such layoffs (and pay cuts) have been more aggressive¹** in the last few months.

The health workers’ strike represents resistance to attacks on the public health system and the public sector in general. Neoliberal policies of the government, under the direction of international financial institutions like the International Monetary Fund (IMF) pose grave danger to the people of Argentina. FeSPoS’s struggle, in conjunction with a broad array of unions and civil society organisations, draws the attention of the world to this danger.

Public health funding has witnessed a series of **sharp cuts over the last year²**, while **military expenditure continued to soar³**. This bad situation became worse with the government’s **austerity budget⁴** for 2019, which slashes social spending by 35%⁵. Immediately this was adopted by the Senate in November 2018, unions and civil



Health professionals in Argentina demonstrate against budget cuts in the health service.

society organisations organised demonstrations against austerity measures. But these were to no avail.

IMF conditionalities for a **\$57.1 billion credit facility**⁶ in total are at the root of the ongoing social crisis. The budget of austerity is **designed for an IMF deal**⁷. Two months before the budget was signed, **global health activists took to the streets in Washington, DC** to highlight the looming health crisis facing the people of Argentina, with the strict targets set by the IMF in its conditionalities.

The impact of austerity measures, including salary “adjustments” and layoffs of staff, on the Argentine health system is severe and will be long-lasting. The struggle of FeSProSa is as much for the millions of Argentinians who

benefit from public health as it is for members of the union.

PSI has consistently argued against how IMF conditionalities constrict social funding, to the detriment of the people. We condemn the regime of fiscal consolidation the IMF has foisted on Argentina. There is also the need for the Argentine government to get its priorities right. Health and social services, not the military, deserve primacy of government funding, if the people are actually at the centre of development and the political system is democratic. □

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4. <https://www.france24.com/en/20181115-argentinias-senate-approves-austerity-budget-adopted-by-the-Argentine-government>
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