RIGHT TO HEALTH

#PublicHealth4All

DECENT WORK

FOR HEALTH FOR ALL

ISSUE 4 - March/April 2018

PUBLIC SERVICES INTERNATIONAL

IN THIS ISSUE

Right to Health is a bi-monthly electronic newsletter published by Public Services International (PSI), in furtherance of the PSI Human Right to Health Global Campaign.
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Decent work for Health for All

This is the first edition of the second series of Right to Health. Subsequent to recommendations of the PSI Health and Social Services Task Force at its meeting in February, the campaign magazine which used to be issued as a bi-monthly newsletter will now be published by PSI on a quarterly basis. It will continue to be a voice for action towards realising health for all.

The health workforce is the backbone of the health and social care delivery system. Achieving health for all requires universal access to a well-motivated health and social workforce, globally. The World Health Organization noted that there will be a shortfall of 18 million health and social workers by 2030 if urgent steps are not taken immediately. And that would make it impossible for universal health care to be instituted, as envisaged in Agenda 2030.

This informed the constitution of the United Nations Secretary General's High-Level Commission on Health Employment and Economic Growth, on which I had the singular honour of representing workers and the public services. The recommendations of the High-Level Commission were far-reaching. They have been taken up as the Working for Health programme, established by the 70th World Health Assembly last year.

The programme aims at quantitative and qualitative expansion of the health and social workforce. It is not enough to have more health workers; decent work should be generalised. The terms and conditions of employment of all health workers must be set in a way that motivates them to continue working in the sector.

Many health and social workers have left the sector to seek employment in other areas of work. Their morale has been dampened by poor remuneration on one hand and overwork on the other. Tens of thousands of health and social workers suffer burnout on the job every year, because most governments appear to be unconcerned with the need to institute safe and effective staffing for health.

The International Labour Organization has also taken a stand to promote decent work in the health sector. At its meeting last November, the ILO Governing Body endorsed the conclusions of the ILO Tripartite Meeting on Improving Employment and Working Conditions in the Health Services held in the second quarter of 2017.

We need all hands on deck to ensure decent work for health workers. National governments and all relevant stakeholders, must prioritize health system strengthening, including ensuring an adequately skilled and compensated health workforce. This can be comprehensively achieved only with a robust public health system.

Private provision of health services, including through Public Private Partnerships (PPPs), entails the commodification of these services as well as of the labour of health workers who deliver them. It is the people who require health and social services the most who suffer from such marketization of health.

A recent disturbing example is the report of a survey of nursing and care homes across the United Kingdom by the University College London. In 91 out of the 92 care homes comprising the sample population, abuse and neglect was generalised. The main reason for this was that the homes, run by private providers as PPPs were understaffed and carers were obviously burnt out.

We cannot allow such a despicable situation to continue. Our health is not for sale and people must come before profit. PSI made it clear at the side event we organised during the 4th Global Forum on Human Resources for Health in Dublin last November, that “achieving universal health care requires our placing people at the centre of the required reimagining of health systems, for the unfolding future.”

PSI remains committed to health for all. And we call on governments across the world to collaborate more closely with health sector unions as social partners, and invest in the improvement of employment and working conditions of health workers to make universal health care a reality.

Rosa Pavanelli

PSI General Secretary

Dr. Ghebreyesus welcomed Ms Pavanelli, assuring her that WHO's role in directing and coordinating international health will be enriched that its relationship with PSI has been formalized.

PSI admitted into Official Relations with WHO

PSI General Secretary meets with WHO Director-General

The World Health Organization (WHO) has established official relations with Public Services International (PSI). The decision was reached by the WHO Executive Board on 26 January, during its 142nd session.

The Plan of Collaboration jointly formulated by WHO and PSI within the context of the WHO framework of engagement with non-state actors (FENSA) for the 2018-2020 period, was equally endorsed by the WHO Executive Board. It focuses on the "Working for Health" Five-Year Action Plan for Health Employment and Inclusive Economic Growth (2017-2022) discussed and adopted at the 70th World Health Assembly last May.

On 8 February, Rosa Pavanelli, PSI General Secretary, met with Dr Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization, at the WHO headquarters. She expressed PSI's appreciation of the establishment of this new form of relations between both organisations.

Dr Ghebreyesus stated that WHO is looking forward to working with PSI "to expand and transform the global health workforce." The formal relations now instituted will enable health workers organised as trade unions to better contribute to the policy process in international health. PSI can now participate and intervene, within the decision-making structures of the WHO, internationally and regionally.

PSI and its affiliates will utilise this ground-breaking development to ensure that concerns of health workers and defence of public health continue to be pivotal issues in the policy process worldwide, towards a better world with quality health for all.

During her visit to the WHO, the PSI General Secretary gave a clear indication on this when she stressed the need for increased public funding of health. It is only the public health system, she said, that can guarantee universal health care, since private providers are guided by for-profit motives.

She also noted that a vibrant atmosphere of social dialogue is necessary for harmonious labour relations. When unions' right to organise and collective bargaining is not respected, conflicts which could hinder the delivery of health services are likely to arise. This becomes particularly calamitous during health emergencies as evidenced by developments in Liberia during the Ebola outbreak, because of the government's violation of health workers´ trade and labour rights.

Dr Ghebreyesus agreed with the PSI General Secretary that emphasis must be placed on ensuring the safety and security of health workers, as the world needs them to be living heroes, saving lives and making the world better. He also stressed the importance of addressing health worker migration in a mutually beneficial way for all countries.

The Director-General then assured Rosa Pavanelli of WHO's commitment to working closely with PSI at the international and regional levels of its work. ❑

PSI Health and Social Services Task Force Meets

Affirms urgent need for Right to Health for all

The Public Services International Health and Social Services Task Force (HSSTF) met on 15-16 February, at the International Labour Office in Geneva. In attendance were over 30 health and social sector union leaders from across the world. They shared experiences and ideas on work in the sector and campaigning for the Right to Health.

The first phase of the PSI Right to Health campaign was launched on 12 December 2016. Following the renewed mandate for the campaign at the PSI World Congress last year, attendees committed to stepping it up across the world.

Participants addressed the need for shared strategies on organizing health workers, as the best way to grow the movement's power.

Dr Jorge Yabkowski from the Argentinian union FESPROSA discussed how his union has directly integrated the campaign into its wider activities.

Panelists from the International Labour Organization (ILO) and World Health Organization (WHO) highlighted the need for social dialogue and respect for health workers who carry out frontline work for the good of their communities. Dr Tana Wuliji from the WHO called for action, saying:

"The scale of change that is required from the status quo is so immense that it is imperative that we work together. There are positive signals of progress in some parts of the world. But we need it to catch fire".

Dr Wuliji made clear the organisation's support for public investment in healthcare:

"The countries that have made the most gains towards achieving universal health coverage are those that have invested in public health".

The Task Force meeting came just days after the WHO formalized official relations with PSI. PSI can now participate and intervene within the decision-making structures of the WHO, internationally and regionally.

ILO health sector Expert Christiane Wiskow said: "The Health Sector is not a burden to economies but contributes to economic growth".

The ILO held its Tripartite Meeting on Improving Employment and Working Conditions in the Health Services in April last year. Wiskow, who works in the ILO Sectoral Policies Department, which organised the meeting, referred to it as successful and important for future cooperation.

"We met to discuss decent work strategies that effectively address health workforce shortages, as a prerequisite to enable provision of equal access to health care for all."

Candice Owley, Vice President of the American Federation of Teachers, highlighted the dangers of a lack of public provision:

"In the USA the number one cause of bankruptcy is having to pay medical bills".

The panelists from WHO and ILO also highlighted the working conditions of female employees in the health sector, pointing out that these have a strong tendency to be worse compared to other sectors. 70 percent of the health and social workforce consists of women. They play essential roles in healthcare delivery globally.

The downside is that some women remain in low skilled jobs and are often at the bottom of the work hierarchy. There are challenging gender gaps in the health and social sector. Given the continued widening of the economic gender gap, it will not be closed for another 217 years, except if farreaching measures are urgently taken. According to Dr Tana Wuliji:

"We cannot wait for another 217 years to achieve the goal of equal pay in the health sector. We have a serious problem and we should deal with it now."

Rounding up the session, PSI's Health and Social Services Sector Officer Baba Aye said:

"We have discussed a wide range of issues and this discussion will form the basis of our plan of work in the sector, within the overarching context of the PSI People Over Profit Programme of Action: 2018-2022, with priority accorded to our campaign for universal public health care." ❑

Young health activist watcher at the WHO Executive Board

The invaluable experience of a WHO Watcher

Sherif Olanrewaju

For the second year, in collaboration with the People's Health Movement (PHM) on the Global Health Watch programme which PHM organizes for the civil society movement in international health, a young health activist from a PSI affiliate participated in the WHO Watch at the World Health Organization Executive Board session in January 2018.

Sherif Olanrewaju from NANNM, Nigeria, who attended the WHO EB 142 Watch, reports on his invaluable experience.

My name is Sherif Adewale OLANREWAJU, I am a psychiatric/mental health nurse and national youth coordinator of the National Association of Nigeria Nurses and Midwives (NANNM) a PSI affiliate. I am also the elected assistant secretary of Nigeria Labour Congress (NLC) youth committee. This year, I had the opportunity to be the first from the African region to represent PSI as a member of the WHO Executive Board Watch team during the 142nd WHO EB session. I consider this opportunity as an invaluable capacity building avenue for young health professionals and labour leaders to gain an understanding of the dynamics of global health politics and policy formulation process.

I joined 14 other health care professional activists and academics from across the globe for an intensive four-day workshop at the PSI head office in Ferney-Voltaire, to scrutinize the agenda for the WHO 142nd Executive Board meeting. We used this time to make presentations, critique documents and make critical analysis of the significance of all items on the agenda as they affect people's health. I presented two items on the agenda: Non-communicable diseases and WHO reform. Working assiduously, we came up with our positions from the civil society organizations' perspective and thus developed statements and policy briefs which advocated that decisions taken by the executive board will place people over profit.

The 5th day was used to engage in consultations with other civil society organizations. We shared presentations about our views and positions to enable us to adopt a common stance with the civil society movement organisations. The Executive Board meeting provided not only a platform for a deeper insight into global health politics, but also an excellent opportunity to make small contributions to help improve the health of billions of lives. As WHO watchers, we engaged in lobbying delegates from several countries as they sought to make contributions on the issues that affect the poor and marginalized. We also provided a strong opposition to the anti-people's agenda, notably corporate power under the guise of Public Private Partnerships (PPP).

To provide wide publicity and increase awareness, we engaged thousands of people via social media using Skype, Facebook and Twitter, thus increasing accessibility to the discussion. Many delegates were willing to engage with us and consider our views. I look forward to building on the gains of this invaluable experience by engaging delegates from my region to future WHO meetings and advocating for health policies with positive impacts on people's health. I also intend to hold talks with young labour leaders, health activists and academics in my region to sensitize them on the importance of being available to make contributions during the formulation phase of health policies. This will not only afford them the opportunity to contribute to policy formulation, but also reduce the conflicts that may arise between the unions and government at the policy implementation phase.

The PHM organizes a similar Watch at the World Health Assembly. Lena Vennberg for Vadforbundet, Sweden, participated in the WHA Watch last May. ❑

Funding, accountability and service delivery required

Over the last year, there have been renewed deliberations on what direction the pathways to health for all in Africa would take. The 1st World Health Organization Africa Forum held in Kigali, Rwanda on 27-28 June 2017 set the context for this, with the theme: "*Putting People First: The Road to Universal Health Coverage in Africa".* The Geneva Graduate Institute encouraged further discussion on the subject with a panel discussion on "The Future of Health in Africa" on 23 January 2018.

This discourse continued on 8-9 March 2018, when governments and a broad range of non-state actors gathered once again in Kigali, Rwanda, for the Sustainable Development Goals Centre for Africa (SDGC/A) conference on regulatory frameworks for ensuring accountability in the health system.

Dr Belay Begashaw, the SDGCA director general, said in his welcome speech that "despite global declarations and goals, government commitments and pledges, calls, actions and targeted interventions, many health issues that are no longer issues in other countries continue to be huge issues in Africa."

At the crux of this worrisome situation lies the dearth of much needed government action in funding health and providing adequate leadership for building resilient health systems. Ms Zouera Youssoufou, the chief executive of Dangote Foundation put this in perspective, saying "we know it is the responsibility of governments to fund healthcare, but unfortunately they have left the duty and responsibility to private sectors and donors."

As WHO Afro noted in its 1st Forum last year, "equitable access to health care and prevention remains a distant goal in most countries" on the continent, even as the health challenges posed by "old enemies" such as HIV, tuberculosis and malaria are exacerbated by "new threats" such as non-communicable diseases (NCDs), urbanization and climate change. And despite gains made in maternal and child health, more than half of all preventable maternal deaths in the world occur in Africa.

A thread that continually runs through this new discourse on the parlous state of health in Africa and how to arrest the situation is the need for "home-grown" solutions. But, despite a consensus that governments must do more, the supposedly home-grown solutions are hinged on Public-Private Partnerships (PPPs).

The journey of a million miles might start with a single step. But not if this step is in the wrong

direction. PPPs are part of the broad gamut of neoliberal policies and practices that arrested the development of Africa in its first few decades of independence. The primary aim of business, even in "partnerships" with governments, is to make profit.

The argument that African states do not have enough resources to provide universal public healthcare is on one hand ideological and on the other an argument which fails to put the problem within its proper context.

African heads of states and governments made a commitment to set aside at least 15% of their countries' annual budgets for health in the Abuja Declaration of April 2001. Seventeen years later, less than 10% of African countries have acted on that commitment. These include Rwanda, which is not one of the wealthier countries. Meanwhile, elected public officials in Kenya and Nigeria are some of the highest paid in the world, yet they are failing to meet the Abuja Declaration targets.

The major problem is poor prioritisation of health by governments in real terms, rather than a lack of resources.

This, however, does not downplay the fiscal challenges that African governments face. The roots of these fiscal challenges constitute the context which must be understood and changed.

This context has two fundamental aspects: tightening of governments' fiscal policy space, due to their implementation of international financial institutions dictates, and unjust (including, but not limited to, illicit) financial flows out of Africa, orchestrated by transnational corporations.

The crisis preparedness of already fragile health systems has been undermined because of the economic reforms advocated by the International Monetary Fund (IMF), which promote cuts in public health funding. **This contributed significantly** to the extent of devastation wrought by the 2014 Ebola outbreak in Guinea, Liberia and Sierra Leone.

The report of the African Union/ United Nations Economic Commission for Africa **High-Level Panel on Illicit Financial Flows**, chaired by Thabo Mbeki, the former South African president, reveals that Africa has lost over $1 trillion to illicit financial flows over the last fifty years and continues to lose more than $500bn every year. A fraction of this amount is enough to guarantee universal access to quality public healthcare, without resorting to loans or support from philanthrocapitalist ventures.

For a future with health for all in Africa, we do not need partnerships that directly promote for-profit private interests or indirectly through philanthrocapitalist platforms, rather, governments should live up to their responsibility of providing adequate funding and an enabling environment for public health. Tax justice must also be promoted for domestic resource mobilisation.

PPPs might arguably appear to be a solution in the short run. It can take decades for the depths of their adverse impact on healthcare delivery to appear. Governments in countries like the United Kingdom which were early proponents of the PPP model in the 1980s, now criticize the costs of such private financing initiatives. But, as a **report of the Jubilee Debt Campaign** at the end of last year reveals, they continue to promote this failed model in Africa and other parts of the developing world.

However, in a stunning concurrence with the fact that **"Public Private Partnerships suffer from widespread shortcomings and limited benefits,"** the European Court of Auditors recently stated that "EU co-financed Public Private Partnerships (PPPs) cannot be regarded as an economically viable option for delivering public infrastructure." There can hardly be any more damning assertion for PPPs to be rejected in conceptualising a meaningful future for health in Africa.

On the contrary, policy-makers can draw inspiration from **a new study published in the British Medical Journal** in March 2018. It shows, with a seven-year proactive community case management (ProCCM) pilot intervention, that; expanding **"free healthcare to everyone"** is both possible (even in one of the poorest countries in Africa), and necessary for achieving significant improvement in health outcomes.

Health is a fundamental human right and can be so realised only as universal public healthcare, where children, women and men do not die because they cannot afford quality healthcare or go bankrupt to meet health expenses.

The neoliberal model of maldevelopment which prioritises profit over people should be jettisoned for a social model of sustainable development with people at its centre. PSI and its affiliates in Africa and around the world are committed to this. We will continue to mobilise for this pathway to a better future. Our health is not for sale. ❑

Right to health in Tanzania

by Hery H. Mkunda

The World Health Organization (WHO) defines health as "the state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."

Health is one of the main determinant factors for measuring the social and economic development of any nation. In Tanzania, according to the country's Constitution, health is a right and not a privilege. As Article (11), (1) of the Constitution states,

"The state authority shall make appropriate provision for the realization of a person's right to work, to self-education and social welfare at time of old age, sickness, or disability and in other cases of incapacity. Without prejudice to those rights, the state authority shall make provisions to ensure that every person earn his livelihood."

The Tanzanian government has taken some steps to improve health access to all citizens, including a budget increase of 35 per cent. But this is not matched by improvement in the working conditions of health workers who deliver health services to the populace. Terms and conditions of employment in the sector remain grossly inadequate.

Government investment has been mainly concentrated in new infrastructure, whereas healthcare staff are demanding more training, health and safety protection and salary increases.

Tanzania has more health workers per 1,000 of the population compared to several other sub-Saharan African countries, but the ratio remains low. This is partly due to the small number of students in medical and health schools. The government has increased the number of students enrolled to pursue health related courses from 13,002 in 2015/2016 to 13,632 in 2016/2017.

The government has worked on increasing the number of new employees in the health sector. The figure went from 7,471 to 9,345 in 2014, and continues to increase.

However, many health workers migrate abroad or to other sectors, due to retention-related factors including poor remuneration and adverse working conditions.

As part of the National Health Security Plan, 2017/2021 aimed to combat epidemic disease like Ebola, 110 health workers have been trained on how to overcome epidemic infectious diseases.

However, the provision of immunization and vaccination, which is the best measure against Hepatitis C and Ebola, is inadequate. The trade unions have highlighted the need for the government to also provide health and safety training to prevent health employees from occupational hazards

and diseases such as those linked to Ebola, Hepatitis B and C, HIV/AIDS and other occupation related disease. The International Labour Organization has published a detailed list of the measures employers need to adhere to in providing information, education, training, and protection measures including vaccination to workers:

http://www.ilo.org/legacy/english/protection/safework/cis/products/safetytm/chemcode/09.htm

The health workers' trade union TUGHE believes that to improve both the quality of services in the health sector and productivity in the country, the government should invest more in improving health employees' working conditions and motivation. This includes: providing support for health workers by putting more emphasis on training especially on job training; increasing the number of health employees, and; better pay to boost health workers' morale.

The government needs to recognize that workers are the main resource in providing better health services and to improve our productivity, government needs to invest in health employees through increased salaries, personal emolument and other forms of motivation such as training. For the health sector to operate effectively and efficiently, the government must provide the necessary tools for workers.

National health insurance should be improved and extended to cover all Tanzanians regardless of their income, contribution or economic status. In short, the national health insurance policy must be reviewed to ensure that everyone is covered and enjoy better health services.

The unions, as part of the broader civil society movement, are looking at implementing campaigns to promote the right to health and safety as well as to protect the environment. And this is in line with the Public Services International's global Human Right to Health campaign. Some issues the campaign will cover in Tanzania are trade union responses to climate change as suggested by national climate change strategy 2012, and cleanliness in the workplace to promote good occupational hygiene.

The health sector is a key sector for socio-economic development of the country and a driver of other economic sectors. The government must recognize that by investing in the health workforce, this will improve the living conditions not only of the workers but of the general population. ❑

Liberia: a broken health system needs urgent resuscitation

In a discussion with PSI, George Poe Williams, General Secretary of NAHWUL, Liberia, expressed his heartfelt frustration at the situation in the country, but also his hope for the future with the new government of President George Weah who recently met with the health sector unions, as earlier reported by PSI. Here are some extracts from the discussion.

PSI: George, in your opinion, how do you explain the situation of public services in Liberia today?

GPW: Ever since the civil war in Liberia, the country`s infrastructures have been struggling to recover. Health, education, roads, energy, water, agriculture, and so on have all been badly damaged by 14 years of senseless war! Those whose ideology was to seize power for self-aggrandizement in the under-developed West African nation – who waged a war which took 250,000 lives- have been the ones elected to power since the war ended in 2003, until recently.

PSI: But can you see any improvements on the horizon?

GPW: International donors, and bilateral partners have been making frantic efforts to help our war-ravaged nation recover its basic social services, and improve the livelihood of its citizens who are one of the world's poorest people. Despite the donors' help, particularly during the last 12 years, upgraded social services still fall short of standard levels. The former Vice President, Amb. Joseph Boikai summed it up in a few words, "we (the government) had many opportunities, but we squandered them all."

PSI: Can you tell us about some of the concrete problems that the health sector in Liberia is facing?

GPW: In the face of squandered opportunities lies a broken health system in urgent need of resuscitation. A system in which nearly every patient in need of specialised treatment is referred abroad due to lack of specialists and equipment, if they can afford it, or left to their own devices if they cannot afford it. A system which could not respond to Ebola, meningitis, and is overwhelmed by malaria and scabies! A system without adequate diagnostic equipment,

George Poe Williams

persistently out of medications for patients, and reagents for laboratory investigations. A system with insufficient beds for the number of admissions on a daily basis, without running water and usually out of electricity. A system with no refined ambulance system and constantly short of protective equipment for healthcare workers. The system in which health workers have been treated as disposable goods, had no inputs in the decisions that affected them with government failing to consider our views, and where we would go to work only to contract diseases and were left alone to die! The memories of the Ebola crisis in 2014 is a nightmare that we, Liberian health workers, will live with for the rest of our lives.

PSI: But we have read reports that the Liberian government has developed an investment plan for "Building a Resilient Health System." Do you have any comments about that?

GPW: The reality I have described certainly cannot allow us to refer to the Liberian Health System as "resilient" or anything near to that. It goes without saying then that the "Building a Resilient Health Sector" policy which has been over-emphasized was merely a show off. There were some triages built around many facilities after the Ebola crisis, some level of trainings carried out for health workers, and some left over PPEs from the Ebola crisis. But these are far less than the minimum requirement for a functional Health Care Delivery System. The new administration must see these challenges as urgent and must take the necessary steps to curb the situation and start the real "Building of a Resilient Health System."

PSI: So, what do you think the future brings?

GPW: We acknowledge that the George Weah-led government has inherited a broken health system, but the workers' unions believe that, if the sector is prioritised and given political will, together with the courage to fight corruption, and in collaboration with its partners, the system can definitely be resuscitated. Thankfully, the Weah administration, though too early to grade, seems more willing to listen to the workers' concerns. ❑

Community-based health workers' struggle in Nepal enters a new phase

by Susanna Barria
PSI project coordinator,
South Asia

Two unions of Female Community Health Volunteers (FCHVs) in Nepal decided to work together towards a joint set of demands to amplify their voice and ensure recognition as employees of the government's health system and obtain decent working conditions for their members. This action by the Health Volunteers Organisation of Nepal (HEVON) and Nepal Health Volunteers Association (NEVA) is notable in a context of deep divisions on political lines between the federations to which these two unions belong.

FCHV programme and FCHV unions

There are currently more than 52,000 Female Community Health Volunteers working across Nepal in rural and semi urban areas to provide safe motherhood, child health, family planning and immunization services. FCHVs also treat cases of lower respiratory tract infections and refer more complicated cases to healthcare institutions. Each volunteer provides services to approximately 125 households, representing around 600 people. FCHVs provide the essential link between vulnerable populations in rural and poor communities and the formal health system.

Despite irregular working hours due to dealing with emergencies as well as routine work for around six hours a day and up to six days a week, FCHVs do not receive a salary and are only provided with limited incentives, such as yearly clothing allowance, refreshment allowance during training and a stipend during vaccination campaigns. In total, these allowances represent less than 10% of the legal minimum wage in Nepal of NPR 9,700 (€75).

Both Pakistan and India also provide large-scale community-based health services through a programme that does not account for a permanent workforce and its remuneration. However, the conditions in Nepal are worse. The Nepalese government invokes the spirit of voluntarism that characterises Nepalese society, the supposedly 'natural' role of women in caring for their families and communities, and the fact that there is no deception involved as the workers are informed from the beginning that they are volunteers. However, FCHVs are increasingly convinced of the legitimacy of their demands to be recognised as workers of the health system, as they showed in a Public Meeting held by PSI in Kathmandu on 12 January.

Public meeting

Under the title 'Challenges facing FCHVs: Learnings from South Asia' participants from Pakistan, India, and Finland joined the meeting in Nepal. Representatives of the government tried to justify the current situation but they were squarely challenged by the FCHVs present in the room.

Bal Krishna Suvedi, Former Director of Family Health Division, Primary Health Care Revitalization Division and Policy, Planning and International Cooperation Division reminded the participants of the origin of the programmes rooted in the history of free-willing voluntarism in times of disasters, such as during earthquakes. Taking the analogy forward, he argued that the rates of maternal and child mortality in remote areas are akin to a health disaster and FCHVs are the modern volunteers responding to it. However, Gita Thing, Vice President of NEVA replied that while disaster response is a punctual event, today FCHVs have a regular monthly and annual workload as well as monthly reporting at the local health facility. "We are proud of the role we play in our community and the contribution we make to saving lives. However, we do not want to be heroes, we just want the basic facilities to be able to do our job and the rights that are associated to our condition as workers of the public health system," she stated.

Dilli Raman Adhikari, Deputy Director, Family Health Department, Ministry of Health and Population of Nepal spoke of the crucial role played by FCHVs in the context of a severe shortage of skilled health workforce, especially in remote areas of the Himalayan region. "In the mountains, FCHVs are the doctors of their communities. They are the most accessible health workers in their communities," he said. He then spoke of the motivational factors and the in-kind and in cash support that the government provides to FCHVs. In-kind support includes bicycles, umbrellas, and a bag. Yet, only 8% of FCHVs receive this in-kind support. With regard to cash allowances, Adhikari argued that the clothing allowance, refreshment allowance during trainings and stipend during vaccination days have been increased on a regular basis and are now NPR 7000 a year, NPR 150 a day and NPR 400 a day respectively. Bagawati Ghimire, President of HEVON, took the floor to respond that this support is inadequate. "A yearly clothing allowance was enough in the 1990s, it is not enough anymore in today's economic context. Today a salary is required to keep our families going," she affirmed.

Representatives of Nepalese National Centres General Federation of Nepalese Trade Unions (GEFONT) and Nepal Trade Union Congress (NTUC) expressed their support for the demand to be recognised as workers. Researcher Bijoya Roy, showed that while there are similar programmes in other countries in South Asia, in those countries and under pressure from the unions, governments have agreed to some of the demands of the workers. This is for instance the case in Pakistan where the equivalent workforce called Lady Health Workers (LHWs) have not only been recognised as workers, but absorbed as permanent employees. Today LHWs receive the current minimum wage of PKR 15,000 per month (around €110).

Way forward

There are currently three unions of FCHVs active in Nepal. NEVA, registered in 2009, and Female Health Worker Association, FeHWA or Mahila Swasthya Sebika Shramik Sangh, registered in 2012, were instrumental in ensuring regular increases in the allowances paid to FCHVs, such as the introduction of an annual clothing allowance, as well as ensuring that the government provides them with an identity card accredited by the Ministry of Health and Population. NEVA currently has 5,000 members. HEVON is a newer union, registered in 2016, that counts 12,000 non-paying members. HEVON emerged from the union of health workers Health Professionals Organisation of Nepal (HEPON), as a group wishing to work in a more focused way on the issues specific to this category of workers. Over the past year, NEVA and HEVON have had the opportunity to come together to organise events in different parts of the country, based on which they decided to take this to the next step and develop a common set of demands.

Nepal is in a period of transition as it restructures its governance system into a federal democracy constituted of a union of seven provinces. Elections held at the end of 2017 saw a left-wing coalition sweeping parliament, bringing expectations that the new government will prioritise social sectors, including healthcare. However, it is not clear how the division of responsibilities between the Union and the Provinces will affect the employment structure of FCHVs and their demand for regularisation. Trade unions need to increase their organisational strength at the Provincial level.

Further, public health experts have raised concerns that providing decent wages to FCHVs will affect the sustainability of the programme in the current situation of limited resources. The FCHV programme is fully funded by international aid. Trade unions will need to present arguments showing how those resources can be obtained and collected. Currently, subsidiaries of foreign companies operating in Nepal enjoy very low tax rates. Demands for tax justice can bring together a broader coalition, including other workers in the public health system and the progressive civil society movement along with FCHVs in a demand for universal and quality public healthcare services.

Finally, a key challenge lies in the need to increase the confidence of community-based health workers so that they can argue the legitimacy of their demands and win over the support of the broader public, especially in their communities. Low levels of literacy mean many FCHVs feel inadequate to make claims on formal employment jobs in a context of high informality of the economy and rampant under-employment. The highly informal nature of FCHVs' employment makes it difficult for them to identify with the common understanding of what a worker is. It is through discussion that these doubts can be clarified, and this is a challenge that the leadership of the unions involved in this struggle need to tackle. ❑

India's health system's challenges

by Susanna Barria
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On 17 January 2018, in an enormous show of strength and determination close to 6 million community-based workers in health, education, nutrition and care services, 90% of them women, went on strike across India. But less than a month later, when the union budget was presented, their legitimate demands for decent work and quality public services were ignored. Worse, the healthcare budget is shifting to a system based on private insurance packages. The Indian government has not only failed the promise of universal access to quality healthcare, but contributes to furthering the privatisation of the country's health system.

17 January All India Strike

A joint platform of 10 national trade unions centres made the call for the 17 January strike. It was the first call of its kind for a particular sector. Despite government's threats of retrenchment and cuts of up to a month's remuneration, close to 60% of the workforce joined the call.

More than 10 million workers are employed under 'temporary' government programmes, or schemes, to provide crucial nutrition, health, education and care services to their communities. For instance, under the National Health Mission (NHM), close to 1 million community-based health workers, called Accredited Social Health Activists or ASHAs, provide maternal care, neonatal care, infant care, vaccination, family planning and other essential services to the most vulnerable populations. They provide an essential link between the local health facility and the community. Similarly, 2.7 million Anganwadi workers under the Integrated Child Development Services (ICDS) Scheme provide for child nutrition and care (crèche) and 2.8 million workers under the Mid-Day Meal Scheme cook and serve nutritious meals to school children. Close to 4 million workers are deployed under other similar schemes.

Yet, these community-based workers are not recognised as workers, and receive neither minimum wages nor social security. Instead, they are given incentives or honorarium, which are as low as INR 1,000 (Euros 12.5) a month for some categories of workers. This is despite the fact that the 45th Session of the Indian Labour Conference, held in May 2013, recommended that scheme workers be recognised as workers, and the provision of minimum wage and social security, including pensions.

These crucial government programmes are also threatened by budget cuts and structural changes. These include involving organisations linked

to private companies, such as food companies, in the provision of the services; making access difficult for the target populations; and replacing universal services with targeted cash transfers. The government has given no sign of interest to address the issues that were raised in the strike call.

Decline in Health Budget 2018-19

One of the key demands of the strike was adequate allocations for government programmes providing basic services to the masses so that workers can earn at least a minimum wage and services offered with adequate infrastructure and quality of provision.

However, the Budget 2018-19 presented by the Central Government on 1 February did not make the appropriate allocations. Despite the growing crisis in access to health care in the country, the allocation to healthcare has decreased in real terms. For 2018-2019, the government has allocated INR 546.67 billion, which represents only a 2.5% increase (lower than the inflation rate) over the revised estimates of INR 531.98 billion the previous year. The allocation for the principal health programme, the NHM under which the ASHAs work, received less allocation than what was spent the previous year (INR 306.34 billion against INR 312.92 billion last year). The demands of ASHAs and other scheme workers alike have not been taken into account in this budget.

Furthering Privatisation

While the NHM has seen its budgetary allocation decrease, the government announced a new flagship programme, the National Health Protection Scheme (NHPS), also known as 'Modicare'. Under this programme, 100 million families would be covered for hospitalisation expenses up to INR 500,000 (Euros 6,250) per year for a family. Like earlier public funded insurance schemes in India, only hospitalisation is covered for a specific list of procedures, and treatment can be provided either in public or in private facilities. In practice, this boosts the private sector. For instance, in the state of Andhra Pradesh where the oldest such scheme is implemented, a large majority (77% in the period from 2007 to 2013) of public resources get directed to treatment in the private sector.

What is more, most infectious diseases, chronic diseases, and other health issues that require prolonged treatment without hospitalisation are excluded from coverage, despite their prevalence in the population (in Andhra Pradesh, 25% of the state budget was used to cover 2% of the burden of disease). Thus, public resources are wilfully directed away from already neglected primary and secondary care facilities towards tertiary care facilities where the private sector dominates.

Firstly, necessary allocations not been made to respond to the demands of the workers, and secondly, the government is directing public resources to strengthen an already dominant private health sector by assuring a steady clientele through the "largest government funded health care programme."

This strategy of backdoor privatisation has been called out by the progressive public health community in India. The trade union platform of scheme workers is planning further agitations and mobilisations to create a broader platform against the threat to the provision of basic services. Arguably the next steps will require state-based mobilisation strategies. On 25 February, the First National Convention of United Nurses Association (UNA), a PSI affiliate that has been fighting low wages and informal employment conditions in the private and public hospitals, was held. Increased informalisation of employment in public hospitals are another outcome of the neglect of public facilities. On the other hand, the dominant role of the private sector contributes to the lack of implementation of existing laws, including labour laws, in private facilities.

Yet, as long as these different movements work on their own, their impact will remain limited. Broad coalitions and joint strategies are essential to derail the plans of a government that is committed to the agenda of dismantling public services across the board. ❑

For more information:

Why are Scheme Workers going on an All India Strike, Interview with AR Sindhu, 15 January 2018 https://newsclick.in/why-are-scheme-workers-going-all-india-strike

Health Budget Could Have Been About People, But Now It's About Markets, by Ravi Duggal, 6 February 2018 https://thewire.in/221309/health-budget-2018-markets-nhrm/

Who is cheering for 'Modicare'? by Amit Sengupta, Newsclick, 6 February 2018 https://newsclick.in/who-cheering-modicare

Exposing the mirage of 'Modicare', Statement by Jan Swasthya Abhiyan, 21 February 2018 https://kafila.online/2018/02/21/exposing-the-mirage-of-modicare-jan-

UNISON's "Pay Up Now" Campaign's strategy for better pay

by Christina McAnea, Assistant General Secretary for UNISON

After the UK's 2017 general election, UNISON established its "Pay Up Now!" campaign, calling for the end of the public sector pay cap and the restoration of real terms pay rises for all public sector workers.

Since the global financial crisis of 2008, the UK's public sector workers have been subjected to a brutal decade of pay cuts and job losses.

Successive Conservative governments have persisted with an ideologically-driven austerity agenda that seeks to slash the size of the state and either deliver public services on the cheap, or stop delivering them altogether. At the heart of the austerity agenda was a public sector pay cap of 1%, implemented in 2010, which sought to ensure that pay for all public servants was held at or around existing levels in real terms.

In reality – even during years of low inflation – this pay cap meant an annual real terms pay cut for the public sector. Public sector pay rose by just 4.4% between 2010 and 2016 while the cost of living rose by 22%. So, a public sector worker who received the median public sector wage in 2010 and since then subject to the two year pay freeze followed by the 1% pay cap, has seen the value of her/his wage drop by £4,781 per year.

Throughout the years of austerity, UNISON has led campaigns against both the government's pay policies and the wider austerity agenda. However, this campaigning was given greater impetus – and increased opportunity of success – following the 2017 general election.

Whilst in 2015, the Conservative Party had achieved a surprise majority of six in the House of Commons, the 2017 general election – called by Prime Minister May in order to increase her mandate – led to a hung Parliament without a firm majority for ongoing austerity.

It was in the days and weeks after the election that UNISON's "Pay Up Now!" campaign was established to make the case for ending the public sector pay cap and restoring real terms pay rises for all public sector workers – a case that suddenly had a far more receptive audience in Parliament than only a few months before.

Two audiences

From the outset, the campaign had two clear audiences. The first was UNISON members, on the front line in public services across the UK, and in desperate need of a pay rise. The second vital audience was those in a position to secure a fundamentally different pay policy: Members of Parliament. The union decided that the campaign would not focus too greatly on wider public appeal due to the time constraints and the need to focus resources on the smaller audience who could win the argument for better pay.

Firstly, it was important to mobilise UNISON's 1.3 million members nationally, regionally and through their workplaces at branch level – so that a clear message on public sector pay could be delivered in communities throughout the

country. The union produced campaign materials, fact sheets, pay calculators and other resources centrally and disseminated them to members of the union for campaigning at a local level. These resources were subsequently used to show support for the campaign through local lobbying, press stunts and social media campaigning.

The lobbying was designed with the intention of ramping up pressure on MPs.

From the outset of the campaign, UNISON wrote to all MPs with carefully targeted messages. Conservative MPs were written to first, outlining UNISON's position on pay, explaining the impact this has had on public services and calling on them to support the campaign.

Crucially, the letters referred to the number of UNISON members living in each MP's constituency, reminding them of the substantial number of their constituents affected by their party's decisions in government.

Letters were then sent to opposition MPs, thanking them for their ongoing support for the campaign (every other party in Parliament has indicated that they would support an end to the pay cap for at least some public sector workers). Messages to these MPs included a campaign pack featuring materials (posters, placards, badges, stickers) which parliamentarians could then use to advertise their support for the campaign in Parliament, in their constituencies and on social media.

This preliminary lobbying of MPs had the desired effect, with ten Conservative MPs responding either to express support, or to ask for further meetings with constituents and/or UNISON representatives.

Mapping Members of Parliament

At this stage, UNISON conducted a thorough mapping of MPs, based on their views on pay (either shared publicly, identified through lobbying or gleaned through political intelligence gathering). This divided parliament into a number of groupings, which could broadly be described as:

- Group 1 - Those in favour of a public sector pay rise, and willing to vote accordingly in Parliament (all opposition MPs)
- Group 2 - Those in favour of a public sector pay rise, and open to the idea of supporting that position in Parliament (as many as 20 Conservative MPs plus the DUP)
- Group 3 - Those opposed to a public sector pay rise, either because they don't believe public servants need/deserve one, because they consider it unaffordable or because they don't want to vote against the government (most conservative MPs).

Based on this analysis, we believed that there were enough MPs – if lobbied effectively – to force the government to abandon the public sector pay cap and move towards real terms pay rises for public sector workers.

Further targeted lobbying took place to try and increase the size of group 2 – the group most critical to the success of the campaign. This included identifying the Conservative-held seats where the UNISON membership outnumbered the majority of the incumbent MP. All UNISON members in these seats were contacted by email and provided with a draft letter to send to their MP, calling on them to oppose the current pay policy and reminding them of the large number of UNISON members in their local electorate. The union also contacted local newspapers to reinforce the pressure on these most vulnerable MPs to change their position.

Successful petition

At the same time, UNISON used the British government's Parliamentary Petition website to maximum effect. Any petitions on the site which receive 100,000 signatures are automatically considered for debate by MPs. In early September – as the petitions website was reactivated after the general election – UNISON launched a petition under the name of General Secretary Dave Prentis, and pushed the petition out to our members through a variety of digital networks. The petition quickly achieved the required number of signatures, securing a Westminster debate on 4 December 2017.

Further lobbying took place in October 2017, with a national lobby of Parliament on public sector pay. This was organised by the Trade Union Congress (TUC) but with UNISON acting as the lead union and providing the vast majority of members lobbying on the day. Particular focus was given to those MPs either already identified as being in "group 2" or who political intelligence suggested were open to approach.

In November the government held their annual budget statement – and our campaign achieved a clear breakthrough. From September onwards the government had alluded to an end to the public sector pay cap, but the budget was the clearest indication that this was the case. Furthermore, the Chancellor stated that they were specifically seeking to achieve a pay deal in the National Health Service (NHS), and that if a deal was reached, funding could be made available to pay for it.

The budget was followed by the parliamentary debate on public sector pay secured by our petition. A fresh round of lobbying of MPs was conducted – including a post budget email to all UNISON members, requesting them to ask their MP to attend the debate. UNISON reiterated our demands and made it clear that whilst the budget marked a change in government policy, that wasn't enough – it would take real action, and funding, from the government to deliver real pay rises for all public sector workers.

MP support

As a result of our lobbying, more than 80 MPs attended the debate to show their support, despite it clashing with an important Brexit debate and vote happening in Parliament at the same time. Opposition MPs were clear in their support for our campaign – with 26 separate references to UNISON made during the debate – although the government response showed an unwillingness to commit to anything more than a notional lifting of the pay cap.

However, in the weeks following the budget and the pay debate, circumstances began to change with regards to pay. In Local Government and Health – the two groups which cover the majority of UNISON membership – negotiations either have or are likely to result in pay offers in excess of the previous pay cap. We are currently consulting with our local government members in England and Wales on a pay offer with a minimum of 2% but worth up to 16% for the lowest paid. In the NHS we are coming to the end of extensive negotiations which we expect to result in an offer worth considerably more than 1%.

There is still a long way to go to achieve a fair and decent pay policy in the UK – one where above inflation pay rises each year are the norm – but there are significant signs that the campaigns run by UNISON and the other public sector unions are having a real impact. ❑

Also read: http://www.world-psi.org/en/equal-pay-and-closing-gender-pay-gap

Strike in France: In Defence of Quality Elderly Care

Social workers delivering home care, including in Housing Facilities for the Dependent Elderly (EHPAD) across France embarked on a one-day strike on 30 January. This was to draw attention to several pressing problems confronting elderly care, which the authorities have failed to address.

The trade unions which called the strike were CFDT, CGT, FO, SUD, UNSA, CFTC and CFE-CGC. They were protesting the insufficient resources allocated by government, which has resulted in reduction of the social services workforce responsible for elderly care. This runs against the "Great Age Solidarity Plan" unveiled by the French government in 2006, which envisaged the need for increased staffing levels by 2012.

On the contrary, as a survey by CFDT-Sante Sociaux last year shows, staff strength and working conditions in health and social services are grossly inadequate. The struggle of French unions for satisfactory staffing levels for elderly care is a struggle for respect and proper care for the aged, and also in defence of social workers, many of whom suffer burnouts as a result of overwork in desperate attempts to fill the personnel gaps of care for elderly people.

PSI and its affiliates have always stood up for safe and effective staffing for health and social services. The health and social workforce constitute the backbone of services delivery in the sector. Quality elderly care, like other social services, cannot be provided without enough well-motivated staff to provide this.

It is thus urgent and essential to improve the working conditions for staff in nursing homes as well as for those that provide home care. It is equally time for the French authorities to employ more social workers in line with the Great Age Solidarity Plan, as demographic changes are resulting in an increasing number of the elderly, who need to be cared for.

The 30 January strike is a warning sign that the unions are ready to fight for safe and effective staffing in defence of quality elderly care. PSI calls on the French government to heed their demands: employment of more social workers; improvement of wages and working conditions, and; respect for the elderly who deserve more.

As we noted in the PSI solidarity message to the 33rd Federal Congress of CFDT Santé Sociaux last November, decades of neoliberal policies globally have resulted in dire consequences for the public health system such that "even in the richest of countries, like France, health workers are called on to sacrifice their well-being while caring for others…. And, when health workers suffer, patients don't get the level of care they deserve."

The three-days strike for adequate staffing for the provision of elderly care in France is part of a renewed wave of trade union struggle for a paradigm shift in government policy thrust from the subsisting neoliberal regime to one which prioritises people over profit. ❑

NO to Privatisation of Ambulatory Surgical Care at HUG

The Geneva University Hospitals, HUG (Hôpitaux Universitaires de Genève) issued tenders for private "partners" to run its ambulatory operation services, through a public-partnership (PPP), in February. This, as Le syndicat des services publics (SSP), the PSI Swiss affiliate pointed out, is a surreptitious introduction of privatisation of surgical care.

In a solidarity letter to SSP, PSI General Secretary Rosa Pavanelli commended the principled stance of the union. She noted that, this step by the hospital's management "is a major assault on health as a fundamental human right, which will also have dire consequences on the terms and conditions of work for health workers."

The Lausaunne University Hospitals carried out a similar form of privatisation with dismal consequences for workers and the health system. SSP has been fighting against the privatisation of health services which the Geneva Council of State has been pushing for, over the last thirty years.

This initially took the form of outsourcing of non-clinical services, starting with cleaning services. The resistance led by SSP dammed the tide of this first wave of privatisation. Subsequently, pharmaceutical services were privatised, despite strident opposition by the union.

Precarious work has likewise become entrenched with HUG's use of 1,200 temporary employees every year. They are underpaid and suffer inhumane working conditions. Permanent staff have also been confronted with labour flexibilization strategies by management.

A major example of this was the unilateral decision of the management to increase daily working time of operating nursing assistants from 8 hours to 10 hours last June. The workers organised a fightback. SSP wrote several letters to management demanding a reversal of this decision and the operating theatre nursing assistants organised a demonstration. Victory was won and the 8-hour working time was reinstated.

This victory was inspiring for the workers. But management did not give up with the pursuit of policies that will undermine universal access to quality healthcare and workers' rights, to the benefit of profit for business interests in health, as reflected by this new assault of privatisation.

It rather decided to present the moves to privatise ambulatory surgical services as some form of "social partnership". But, this new policy was reached without any form of social dialogue. And it will also not be in the interest of most people resident in Geneva.

If this policy is successfully implemented, field health workers presently employed by HUG will be at the mercy of considerations of profitability which the private investors will place first over any other consideration, as ins inherent with business interests.

Along with ambulatory care givers, laboratory technologists, radiologists, dieticians, transport staff, security personnel and other related workers will come under the hammer of precarious work.

But SSP and its members have a rich history of struggle and solidarity in the recent period, to inspire their fightback. After the victorious fight against extension of working time in October, they mobilised in solidarity against outsourcing of social care services to the elderly in the Etablissements Médico-Sociaux, EMS (residences for the elderly). Scores of workers walked out, with many joining pickets in defiance.

The struggle continues until victory. Rolling back the rising spate of privatisation in different ways can be achieved only with ceaseless struggle for people over profit. PSI will give every possible support to SSP in its mobilisation to stop privatisation in HUG. PSI and its affiliates all over the world will not relent in challenging PPPs and all forms of privatisation. ❑

#OurHealthIsNotForSale

Oregon's House of Representatives Passes HOPE Amendment in Historic Vote on Health Care

Nurses, legislators and community leaders support state constitutional amendment to recognize health care as a human right.

The Oregon House of Representatives made history on 13 February 2018, voting to pass the HOPE amendment to amend Oregon's Constitution and recognize health care as a fundamental right.

The amendment will advance to the Oregon Senate. If the Senate passes the HOPE amendment, it will be referred to Oregon voters in the November 2018 general election. Oregon Nurses' Association (ONA/AFT) members praised the vote as a historic step to acknowledge and protect Oregonians' basic rights.

"Today's vote confirms what Oregonians already know: everyone deserves access to affordable health care," said ONA nurse practitioner and business owner Diane Solomon. "Access to health care is essential to sustain a thriving state and a healthy economy. The HOPE amendment ensures our families and neighbors can get the care they need, when they need it, without worrying about going bankrupt. Oregon has led health care innovations for decades and we can't go back. It's time to move forward to expand health care access and protect basic rights for all Oregonians."

ONA member and nurse educator Teri Mills said, "As a nurse, I've seen access to health care dramatically improve the lives of thousands of Oregonians. In the face of national threats to health care, we need to stabilize our health care system so all Oregonians have access to affordable care."

On 7 February, more than 100 ONA members, community leaders, health experts and lawmakers showed their support for the HOPE amendment during a public hearing at the State Capitol. Following testimony from supporters, the House Health Care Committee voted to approve the HOPE amendment and advance it to the full House of Representatives. The House voted to pass the amendment on 13 February.

The HOPE Amendment currently has 40 sponsors in the Oregon Legislature. The ONA is the state's largest and most influential nursing organization. It is a professional association and labor union which represents nearly 15,000 nurses across the state. ONA's mission is to advocate for nursing, quality health care and healthy communities. ❑

Click here to read the HOPE Amendment (HJR 203) Link: https://olis.leg.state.or.us/liz/2018R1/Downloads/MeasureDocument/HJR203/A-Engrossed

Read more here: http://www.oregonrn.org/page/news20180213

Movement for the Right to Health: 3,000 people march in Buenos Aires

Over 3,000 working-class people and youth marched on the streets of Buenos Aires on 1 December 2017 to demand universal public healthcare. This marked the opening of the 1st Congress of the Movement for the Right to Health, (Movimiento por el Derecho a la Salud - MDS), for universal health care and against the commodification of health.

The formation of the MDS was inspired by the PSI Human Right to Health global campaign. FeSProSa, a PSI affiliate in the Argentinian health and social sector, played a central role in bringing together civil society organisations and activists, to establish the platform as a national expression of the global campaign.

In a solidarity message to the two-day Congress, PSI noted that the main reason why "health for all" remains a mirage is because health is perceived as a commodity by business interests, whose profit-driven ideology has been adopted by governments across the world. Based on this neoliberal ideology, public health systems have been battered while corporations skim as much as they can as profit, from the 5.8 trillion US$ spent on health every year.

Thus, as we point out in the solidarity message:

The struggle for the right to health and social protection is and must be a challenge to the neoliberal assumptions that inform social and economic policies of states and the international financial institutions.

The Movement for the Right to Health in Argentina is an inspiring step in this struggle, uniting health workers, civil society organisations and communities to fight for People Over Profit. ❑

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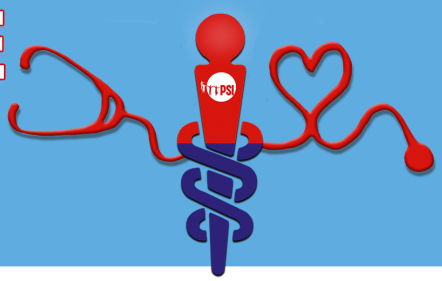

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