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HAI News reports on developments in national and international campaigns on health for all. This newsletter highlights activities of network contacts involved in improving access to medicines, rational drug use and poverty eradication.

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Free Trade Agreements: a boon or a bane?

Passanna Gunasekera & Dr K Bala

Introduction

A Free Trade Agreement (FTA) is defined as “an agreement between two countries or amongst groups of countries aimed at a policy of non-intervention by the State in trade between their nations. Tariffs and non-tariff barriers to trade are usually removed or lowered, whilst each country maintains its own commercial policy towards countries which are not part of the FTA.”

Prime objectives of FTAs are the liberalization of trade in goods and services and the protection of direct foreign investment and intellectual property rights through limiting government regulation. FTAs are considered a serious threat to governments for they reduce the right and power of governments to regulate.

It is often argued that in such a partnership, the smaller economy stands to gain much, or more in relative terms, than the larger economy. However, in many instances the larger economy although appears a “blessing in disguise” in fact gains much more at the expense of the less fortunate nations, pushing them deeper into negative trade, imbalance and poverty.

US' interest in FTAs

The US agenda to enter into bilateral FTAs with individual countries and regional groupings was very well presented by President Bush in his State of the Nation address 2004. Speaking of trade he stated, “**My administration is promoting fair trade to open up new markets for American entrepreneurs, manufacturers and farmers and to create new jobs for Americans**”. Not once did he mention globalization. Barely four years ago, no State of the Union Address would have failed to plug globalization. There was not a word in his address about how trade liberalization, especially in agriculture, can lift millions out of poverty. To understand the reasons for the change from globalization to FTAs, we need to move from the Persian Gulf to the Gulf of Mexico.

At the fourth WTO Ministerial Meeting in Doha in 2001, development moved into the centre of the world trade agenda. Doha was supposed to lead to a better deal from trade for developing countries. But at the WTO's Fifth Ministerial Meeting in Cancun in 2003 “development” went missing and as a result the meeting collapsed.

The stage has been set and the US has now turned its attention to finalizing bilateral FTAs with Australia and more than a dozen other countries. With the US entering into bilateral FTAs with several countries trade barriers will fall around the world. This will open up new markets for American entrepreneurs, manufacturers and farmers and to create new jobs for Americans.

Learning from Mexico and Canada FTA (NAFTA)

The governments of the countries finalizing bilateral agreements should closely examine the experiences of Mexico as well as the USA and Canada in the North American Free Trade Agreement (NAFTA). This is not an attempt to downplay the boons over the banes. However, at a glance from FTA experience in Canada and Mexico, other countries can see the evidence that NAFTA had significantly benefited all the member countries. Mexico's trade with the US and Canada nearly doubled since NAFTA came into force in 1994 and its inflation rate decreased. The Los Angeles Times reports that “NAFTA opened the doors to US\$ 125 billions in foreign investment. At the peak of its impact economists estimated that NAFTA created at least

two million jobs in Mexico as manufacturers took advantage of low cost Mexican labour and proximity to the US Market.” Over half of the 2 million jobs created in Mexico were in the export sector. NAFTA is believed to have rebound Mexico from a crisis state to a state with an economy of healthy growth in productivity and foreign investment.

The boom unfortunately was shortlived. The consequences after the initial boom were nothing but destructive. NAFTA’s limitations took longer to become apparent. Moreover, as the Los Angeles Times reports, “...now they (Mexicans) recognize that Mexico’s 1990 boom was merely hiding profound flaws...The advantages conferred by NAFTA have eroded...trade barriers have fallen around the world, devaluing Mexico’s special status...Mexico has lost nearly half a million manufacturing jobs in the last three years to countries as far as China. And last year, foreign investment declined to its lowest in the last ten years...” The biggest disappointment according to the journal is that NAFTA did not shield Mexico from the broader forces of globalization.

Is this then not sufficient proof to enlighten any government the sorry aftermath that follows the initial boom of bilateral agreements revealing the little benefits on the whole system as the old saying goes is like the calm before the storm...

US and Australian FTA experience

The Australian Government recently completed negotiations for a free trade agreement with the US. The objective was to reduce the barriers to trade between the two countries. Pursuing a FTA with the US would supposedly link Australia more closely with the world's largest and most dynamic economy and lead to higher economic growth, better living standards and better employment opportunities for Australians. However, the most controversial issue of the AUSFTA has been the horse trading of the Pharmaceutical Benefits Scheme (PBS) as stated by many a “step in dismantling Australia's public health system”.

The PBS was established in 1948 and is considered a key component of Australia's health system. It provides reliable and timely access to around 2,500 prescription medicines by subsidizing the cost of a wide variety of these medicines. This gives all Australians access to high-quality medicines at more affordable prices. According to an article on the AID/WATCH website the US drug industry has openly stated that Australia’s PBS is a “barrier to trade” and therefore wants it overhauled. It further stated that “15 companies have even formed a lobby group specifically for this purpose”. Australia is adamant that negotiation of an AUSFTA should not compromise and take away Australians’ access to high quality medicines at affordable prices. The objective and the importance of the PBS to the Australian community have been made clear to the United States from the outset and the Government is committed to ensure that the outcomes from the FTA negotiations will not impair Australia's ability to deliver key policy objectives in health care.

From a public health perspective, privatization and deregulation from FTAs pose barriers to public health. A UN report revealed the requirement of government involvement in a comparatively high level to ensure health services’ accessibility, efficiency and adequate funds (Saltman & Figueras 1998). Major health concerns such as vaccination programs, food and water, safe housing, education, safe working environment, prescription drugs and consumer products are all products of government action, legislation and regulation and not the result of unregulated market forces. The free market notion that health is a commodity and, as such, has a price and can be traded off against other commodities threatens public health strategies, universal healthcare and the concept that health is a human right.

The Doctors Reform Society (DRS) an organization of doctors formed in 1973 to support the introduction of universal health insurance, Medicare, in Australia, expressing its views on the proposed AUSFTA stated “the negotiations in FTAs should be open to full informed public debate and scrutiny before agreements are finalized. They have proposed measures and guidelines to protect Australia’s Health Care System in the interests of the Australian population. The DRS believed that the Australia’s Medicare and Pharmaceutical Benefits Scheme (PBS) were seriously threatened by market driven principles which underlie FTAs.

Specifically in relation to an FTA with the USA the DRS is concerned that Australia is in a position of “unequal bargaining power and US interests will be favoured at the expense of Australian interests”. They believe that public services such as health care and water services will be targeted and future policy flexibility compromised. As US services firms already have access to some commercial services in Australia the new targets would be public services such as health care.

A news release from The Australia Institute Ltd found out that prices for medicines were likely to double if US drug companies were granted the concessions they were demanding under the agreement. Prices could rise by 90 per cent for non-concession card holders and 104 per cent for concession card holders. US drug companies have described the PBS, which costs the Government \$4 billion a year, as insidious because it keeps the price of new drugs low.

According to Professor Richard Laing of the Boston University School of Public Health, “Australia... is the one country which seems to have got it right, that what you want to do in controlling costs is to pay what the drugs are therapeutically worth”. And the Pharmaceutical Benefits Scheme does that” (Laing 2001). The moment the PBS prescription is presented at a pharmacy, one has access to the scheme. Many medicines cost the government much more than the price the consumers pay but the government provides a subsidy for the benefit of the Australian consumers. Concession card holders currently pay \$3.60 towards PBS prescription medicines. Other people pay up to \$22.40.

Branded medicines cost more than others. However, a patient is at liberty to ask the doctor to prescribe a less expensive equivalent or the pharmacist should be able to substitute a less expensive generic equivalent. This scheme in a struggle to protect people and their families who spend large amounts of money on prescription medicines has set a maximum amount the consumer and his/her family would pay for PBS prescription medicines in a calendar year.

US firms have their sights on overseas service industries including health. The free market system of providing healthcare has failed in the USA. The US healthcare industry is being destabilised by falling profits (Levit et al 1998) and is intent on expanding its markets. Australia’s healthcare sector could be seen as a lucrative market.

Australia’s restrictions on the advertising of medicines to consumers is another target of US-Australia FTA negotiations. It is believed that direct advertising would lead to harmful practices being instilled in the minds of the consumers; they would merely get used to purchasing branded drugs and there would be stiff competition among the brands. Direct advertising according to The Australia Institute would result in “pharmaceutical approaches” being replaced “for more appropriate lifestyle therapies in the treatment of illnesses such as obesity and smoking.

Having stated all this, it is not to say that US pharmaceutical companies want the PBS abolished completely. Rather, they want the elements of the PBS that impose constraints on the prices of pharmaceuticals and the ability to advertise directly to consumers removed. However, in the same vein, it must be noted that if these changes occur, the cost of pharmaceuticals in Australia

will rise. The final question that hangs in the air then is whether under the AUSFTA or under any other bilateral agreement who would suffer from the jeopardizing of the health system? It is none other than the poor, the sick and the elderly.

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Network News

**ASIA
- India -**

FMRAI and its action for health and pharmaceuticals

Along with different non governmental organizations involved in health action, the Federation of Medical and Sales Representatives' Associations of India (FMRAI) works actively to develop the national organizations for People's Health Movement (PHM). At the People's Health Assembly in Dhaka four delegates from the FMRAI joined 1400 people from 93 countries. PHA prepared a Peoples Charter for Health and decided to campaign on the Charter and to develop national organizations.

Immediately after the PHA, the groups in India decided to prepare a regular structure. Janswasthya Abhiyan (JSA) was developed to start several programmes throughout the country. Joint General Secretary of FMRAI was elected as one of the secretaries of JSA National Co-ordination Committee. Members of many state units regularly participate in the state and local activities of the JSA.

FMRAI's participation

"Another world is Possible" – with this slogan, initiatives were taken to counter wide spread of syndrome of "There is no alternative". Efforts of different groups who actively oppose globalization from various parts of the world joined together and the World Social Forum (WSF) was formed. The successive meets at Porte Allegre in Brazil showed widespread participation reaching one hundred thousand participants in 2003.

FMRAI also participated in the Asian Social Forum held at Hyderabad in 2003. It was the largest assembly of people from different countries in Asia opposing imperialist neo-liberal globalisation. Andhra Pradesh Medical & Sales Representatives' Association (APMSRU) served the people who came for the meeting by arranging a medical camp while the FMRAI arranged a seminar on "change in patents Act and access to essential drugs".

Pharmaceutical Industry

In the last Conference report of the FMRAI (held in New Delhi in 2000) concern was expressed about the effect of globalization on health. In the meantime, the government of India adopted a new Health Policy largely aiming at more privileged healthcare systems. The policy aimed at spending only 2 per cent of the GDP on health by the year 2005 which is significantly low.

As stated in the above report that the policy change imposed by the government would further deteriorate the common health parameters of our people. A recent report by the National Sample Survey (NSS) establishes the same. With government funded health facilities, only 42 per cent of children below two years of age were vaccinated last year. While government expenditure for health is reduced, private spending on health has grown in leaps and bounds. This has grown to Rs.33.1 per capita now from Rs.5.37 in 1983. For the poorest 40 per cent the hike was Rs.11.71 from Rs.1.66. Though in absolute rupee value the per capita private spending is very low compared to other countries the percentage share of private health expenditure, about 82 per cent of the total health expenditure. This is one of the highest in the world.

Industry performance

Despite the fact that not more than 20 per cent of our people use modern medicines, the turnover of pharmaceutical industry has grown to Rs.200,000 million in 2003. It does not mean that all medicines sold are really needed nor all those who need medicines get it. On the contrary, during the period under review, pharmaceutical industry, in sale of both bulk drugs and formulations have, for the first time, shown very low growth. For the first time, the industry could not register a double-digit growth for three successive years. For the year ending March, 2003, the growth in secondary sales of formulations was just 5.7 per cent (according to ORG-Marg). This was offshoot of the overall economic slow down. Despite such decline in domestic sales performance, over all profit of the industry has been 38.4 per cent, whereas, staff cost of the industry declined from 7.73 per cent to 7.66 per cent. Even though the industry has sold less medicines it earned high profit by reducing staff costs and enhancing prices of medicines. In the year 2003, global slump in pharmaceutical industry has been visible. Growth of the industry all over the world has been 6 to 7 per cent only and in the first six months in India it has been 2.5 per cent only.

The government of India has almost abandoned monitoring the bulk drugs since it becomes redundant in the light of liberalization. The country has stopped production of more than 30 bulk drugs during the last three years forcing large scale import. In the area of serum and vaccines, crisis is more serious since commonly used vaccines are not produced in the government institutions.

Following liberalization of huge number of commodities including bulk drugs and pharmaceutical raw materials, import of drugs and chemicals have sharply grown. In addition, the Indian drug companies are rushing to introduce huge numbers of new drugs which have shot up import to the extent of 400 percent in a year.

The Industry became totally directionless in view of the ensuing change of patent regime thrust by WTO agreement. During this period the large companies started acquisition of other companies simply to broaden their product base and in turn the turnover. Merger, brand selling and acquisition have created an unstable situation. It has not only forced closure of some companies but allowed multinationals to sell their production units. Most of the production units after acquisition have been closed. This process of de-industrialization has made Indian

drug industry more dependent on imports. Acquisition cannot be a solution to the crisis but is reaching its limit very fast. This process has created large scale unemployment and posed a serious threat to job security of the field workers.

The other system adopted by the industry is sales through franchise. In order to reduce distribution costs, this system was initially used but now it is used to replace the entire marketing function. As a result, field workers are thrown out of the parent companies on one side and on the other, large scale casual field workers who are generally not trained and poorly paid are replacing them. This has undermined the need of quality representation and thereby dissemination of scientific knowledge is ignored.

Unethical Marketing Practices

According to the report competition has put the industry to resort to all types of unethical marketing practices; large and small companies are involved in various unethical practices. Linking of prescription for drugs with many types of inducements are not only unethical but bound to become dangerous since this will lead to over-prescription and sale of expensive drugs when cheaper alternatives are available. Attempts to corrupt the medical profession have become widespread and of serious concern. There is no ethical guideline prepared by the government for ethical code of marketing practices. In the absence of which unbridled practices are openly carried out by industry.

Unethical Business Practices

During the last eight years FMRAI has been raising the issue of black marketing of medicines and sale of spurious drugs, the Central Bureau of Investigation (CBI) demanded enquiry and punishment of culprits. But the central government remained silent onlookers even after reports of death after consuming spurious drugs. The World Health Organization declared that the highest amount of spurious drugs world wide are produced in India (35 per cent). With this indictment on our country, the Union Health Minister, Mrs. Sushma Swaraj declared death penalty for the offenders on this count. We welcome the decision of death penalty but whether this Central Govt. is serious one is uncertain. Punishment with life imprisonment is in existence for the culprits manufacturing spurious drugs from 1982. But not a single person has been penalized with this punishment. Moreover many export consignments have been returned on the allegation of them being spurious drugs shattering the image of our country.

Out of total pharmaceutical market of 200,000 millions with around 40 per cent are under the grip of the black marketeers and spurious drug manufacturers. For the public awareness FMRAI members campaigned on this issue many a times. Last year in September, FMRAI sub-units campaigned on this issue all over the country through leaflet distribution. State units demonstrated before respective state Health Ministry in the month of October, 2003.

In January, 2004 FMRAI members demonstrated before the office of the Union Health Ministry and submitted a memorandum to the Health Secretary. FMRAI members collected large numbers of signatures which were submitted to the office of the President of India after meeting him in a delegation. We appraised the President about the means of the effect of this notorious practice. The President of India appreciated the efforts of the FMRAI and assured to discuss the matter further with the officials.

Prices of Medicine

Prices of essential drugs have increased. The Government has been reluctant to enhance activities of the National Pharmaceutical Pricing Authority (NPPA) to monitor prices of the essential drugs. Except for some antibiotics, anti-ulcerants and analgesics, prices of many

drugs including anti-TB drugs were hiked up by the government. This was insufficient and the government wanted to introduce a new drug policy which primarily aimed at wiping off all control on prices, keeping only 30 drugs under price control at present. This decision was challenged by two doctors in the Karnataka High Court which issued a stay order on the government stating that prices of all essential drugs should be kept under price control.

In an unusually quick move the government being eager to waive price control took up the case to Supreme Court. The highest court of the country issued show cause to the government as to why prices of all essential drugs should not be kept under prices control. Now many organizations have become parties to the case and is being pursued in the Supreme Court.

Indian Patent Act 1970

The government of India has now changed most important clauses of the Indian Patents Act, 1970. Except patenting of products, it has followed all the dictates of the WTO Agreement. In view of the development in WTO meeting held at Doha in 2001 these drastic changes were not necessary. In Doha amidst strong pressure from large number of developing countries, particularly from countries in Sub-Saharan Africa, WTO for the first time admitted that strong patent system envisaged in TRIPS Agreement of WTO may cause problems for some countries. For this, they asked TRIPS council to review clauses relating to compulsory licensing and parallel imports. Proponents of WTO agreement suffered a serious set back but did not stop conspiring. US Government successfully upset several meetings of the TRIPS council after the Doha meeting.

Most important observation in this regard is that the countries in the third world could at last assemble and oppose the ills of the WTO agreement which finally scuttled the Cancun meeting in 2003. When such opposition to WTO agreement was coming to the surface, it was not necessary for our government to hurry for drastic change in our patent law. Members of FMRAI in the past three years implemented several programmes of observing protest day and holding conventions, meetings in almost all sub-units.

Public Sector Drug Companies

Under the Vajpayee Government the fate of the Public Sector drug companies are no different than other public sector companies. The companies, which helped our country to achieve self reliance in pharma industry and as a result the reduction of drug prices in the country by MNCs and big Indian companies, are practically either non existent or are counting their days. The Vajpayee Govt. tried all possible means to destroy the companies.

In the struggle of Public Sector Units (PSUs) in drug industry, FMRAI extended all help when requested by the respective unions and also coordinated with Committee of Public Sector Trade Unions (CPSTU). In regard to Hindustan Antibiotics Limited (HAL) FMRAI at its own initiative organized dharna, demonstration, leaflet distribution etc. before the Head Office at Pune and before Chemical and Fertilizer Ministry at Delhi. FMRAI met the Minister in charge at New Delhi several times to save the company. FMRAI took the initiative to submit viability report both in HAL and India Drugs & Pharmaceuticals Limited.

Source: Activity report of the FMRAI

CDMU project to promote rational use of medicines – An unique effort by a voluntary organization in India

Community Development Medicinal Unit [CDMU] West Bengal, a not-for-profit voluntary organisation, established with the objective of improving access to essential medicines among the non-governmental organisation (NGO) sector in India. During the past two decades CDMU has been successfully running a project for procurement and supply of essential drugs of good quality at affordable prices, thereby allowing disadvantaged sections of different communities' access to essential medicines. A central selection team of experts updates CDMU's list of essential drugs and list of suppliers every year after reviewing tender quotations submitted by various drug manufacturers. There are no unproven, hazardous, or irrational drugs in the CDMU list. Suppliers are selected only if they meet certain pre-qualification norms.

A random sample of the procured drugs are tested for quality in approved laboratories. Drugs are purchased in bulk directly from the manufacturers and can therefore be supplied to member organisations or MOs (organisations to which CDMU supplies drugs on a regular or periodic basis), even in remote areas, at substantially lower. CDMU membership has grown from 15 in 1985 to over 400 currently. Majority of the MOs are voluntary organisations in and around West Bengal, providing healthcare on a charitable basis.

It was found out that unless the procurement-distribution of essential drugs could be supplemented with appropriate educational activities upholding the cause of rational use of drugs, the very philosophy behind CDMU's mission would be defeated. This led to the establishment of the CDMU Documentation Centre, dedicated to campaigning on rational drug use. The Documentation Centre through its diverse activities like preparing information-education-communication (IEC) materials, publishing drug bulletins and organizing meetings / workshops / seminars with rational drug use as the focus, aims at influencing doctors and paramedics towards adopting rational prescribing habits and a rational attitude towards drug use, appropriate to the needs of the community they serve. This effort has now been systematized by a new project for promoting the idea of rational use of drugs professionally.

Objectives of the project:

Through this project conscious attempts would be made to help the member organizations in the following manner:

Promoting the concept of rational drug use

Providing unbiased and updated information on essential medicines at the grassroots level

Raising awareness of the concerned population in matters of drug use

Developing a closer liaison between CDMU drug distribution units and MOs

Helping to re-orient and upgrade the existing stores management systems of MOs

Increasing supply of essential medicines by CDMU

Methodology

CDMU has appointed a team, trained in marketing principles, to visit the NGOs working in the field of healthcare delivery in the state of West Bengal. They are meeting the administrators, medics and paramedics to discuss with them the need for rational use of medicines and the benefits which the organisation, in its own sphere of activity, may derive from implementing such a policy. The team utilizes various IEC materials prepared by CDMU, such as flash cards, posters, drug information sheets, in English and in vernacular. Meetings / workshops are arranged for the medics and paramedics in small groups, where resource persons and specialists speak about rational use of drugs (RUD), optimum management of diseases found in their localities, organization of medical stores, etc. Where feasible, meetings are also organized with common people of the locality, exposing them to the various pros and cons of medicine use through posters and group discussions. This in turn will help the MO in implementing RUD in the locality.

CDMU expects to increase the circulation of its existing quarterly newsletter Rational Drug Bulletin published in English. Another bulletin in local vernacular is also published. Handouts on standard treatment of diseases found in the community will also be occasionally published.

The project also entails various surveys. From the inputs available from MOs, local patterns of disease and drug utilization patterns will be analyzed. A manual of standard treatment guideline will be eventually developed. Surveys will also be conducted to find out the access to essential drugs in different localities and the constraints towards implementation of a RUD policy.

Project evaluation

The project will be evaluated every six months for which indicators have been prepared. New indicators may also be developed based on field work. An internal system monitoring team has been set up with CDMU resource persons and administrative staff, to evaluate progress every month. Two external evaluators and an external auditor have been selected to meet in six months for an external evaluation.

The project has been initially designed for three years. Successful implementation will give CDMU the impetus to continue beyond the initial 3 years to further its social commitment in a systematic manner.

- Philippines -

Challenges to Health Work amidst Globalization and War

“Unhampered economic globalization has caused increasing poverty while United States'(US)-led wars of aggression maim and massacre millions of people, destroy social infrastructure and our planet Earth itself,” declared delegates who participated in the International Conference on Challenges in Health Work Amidst Globalization and War held in Manila November 8-10, 2003 organized by the Council for Health and Development (CHD), International League of Peoples' Struggles (ILPS)-Ad Hoc Health Commission, International People's Health Council and the People's Health Movement in which our Health Action International Asia Pacific member Dr Edelina de la Paz is actively involved.

About 120 doctors, nurses, health workers and public health advocates from 11 countries condemned US imperialism for causing untold suffering to people worldwide. Conference delegates also vowed to launch a broader resistance to U.S. intervention and its unilateral policy of preemptive war to combat terrorism.

“The conference became a microscope-like opportunity to explore hard-earned facts about the health of people worldwide and the very root of its continuing decline,” said Dr. Eleanor Jara, Executive Director of the CHD.

Representative Satur Ocampo in his keynote address, of the party list group Bayan Muna Ocampo challenged the health workers to overcome the obstacles they are facing as they go about their duties. He also gave honor to them as he called them 'pillars of the government and society.' Moreover, he said that "a firm grasp of these challenges would also help a great deal in defining your role not only as the sentries of the people's well-being, but also as a potent force for social change....” he said.

Ocampo presented data on the decreasing health budget. He criticized the government for its failure to provide adequate health care to the people. He said that the proposed health budget for 2004 amounts to P12.90 billion, down from this year's P12.98 billion budget. Ocampo noted that

the declining health budget has been the trend for the past eight years. "The consistently low budgetary priority being given to health services contradicts two principles stated in the 1987 Philippine Constitution. These are: that the 'State shall provide social services to the people' and that 'the State shall protect and promote the right to health of the people and instill health consciousness among them.' In the long run, the consequences of poor health services are enormous and will be felt by the people."

Globalization and Assaults on Health Care

Participants of the conference identified the WTO (World Trade Organization), its key agreements General Agreement on Trade in Services (GATS) and Trade-Related Aspects of Intellectual Property Rights (TRIPS), and other similar regional trade agreements as the very evils that cause commercialization of health care, deprivation of basic health services, unaffordable medicines, increasing poverty and untold suffering to all peoples of the world.

Speaking of experiences of developed countries, Martha Roberts of Grassroots Women in Canada said that "In Canada, export in services has tripled in market value during the last 15 years. Service exports in 2002 were worth 58.3 billion dollars." Moreover, she said health technology is a booming export service industry, with over one billion dollars in sales in 1997. Some of the most successful Canadian health exports have included vaccines, diagnostic equipment, contract research services, professional services, telehealth and health management services."

Meanwhile Emma Manuel, President of the Alliance of Health Workers (AHW), speaking on GATS said, "GATS liberalizes the entry of foreign investments and professionals in the service sectors. Laws and regulations of member countries are adjusted so that this will not hamper business, even if this would mean invasion of people's rights and the country's sovereignty. For the past two decades or more, the structural adjustment programs of the IMF-WB have forced governments to dismantle their public services and allow for-profit foreign-based corporations to provide services in health care, education and water.

Citing a report by the World Bank in 1998, Emma Manuel noted that 40 per cent of the World Bank projects are on health, nutrition and population and nearly 75 per cent of projects in sub-Saharan Africa included the establishment or expansion of user fees. The World Bank's health 'reforms' have included making people pay for their health care, reducing public services to a few programs, and turning over the rest of the government services to profit-making endeavors. Fewer and fewer people are able to afford public health services.

Emma Manuel elaborated on the globalization of labor as an integral part of GATS. Trade in services covers movement of health professionals to provide services abroad. "GAT encourages industrialized countries to poach the brightest and the best from poor countries while protecting their own," she said.

Supporting her claims are the following: in Jamaica, over 50 per cent of the nurses are working in North America; 38 per cent of all doctors in the US and 34 per cent of the scientists at NASA are from India. Philippine data shows that there are 300,000 nurses working abroad. At least 50 per cent of health professionals in government hospitals have pending application for abroad. "The rapid deterioration of the health care in the Third World is inevitable with the final blow and pending collapse of the public health system," Manuel concluded.

Wim De Ceukelaire, a Belgian doctor of the International Action for Liberation (Intal), gave a new meaning to TRIPS as Treason and Robbery by Impostors and Patent Swindlers. He said "The availability of medicines is severely restricted because of patents and

unnecessarily high prices. The TRIPS agreement introduces protection of patent rights where they did not exist, raising prices of drugs with 12 to 2000 per cent and makes drug prices rise out of reach for the poor,"he said.

Mira Shiva, of the All India Drug Action Network and a member of the Governing Council of Health Action International Asia Pacific added that TRIPS will wipe out the domestic industry producing cheaper generic equivalents.

According to Maria Hamlin Zuñiga, Global Coordinator of the International People's Health Council, "Health care reform, in many of our countries, is synonymous with the increasing privatization of health services and the contracting of services within the public health system. While those who are wealthy have the opportunity to access health care, the distribution of risks is immensely greater for the poor."

Zuñiga, who hails from Nicaragua, said "Basic services are failing poor people; there is no such thing as a 'one-size-fits-all' recipe to re-address this issue; and social accountability and citizens' control and participation are keys to make things better." Meanwhile added Manuel, "The governments' adherence to the neoliberal doctrine of globalization and the WTO has kept the Third World countries in perpetual crisis." She also said that the solution to the problem of deteriorating health systems rests on changing the whole international economic order.

Effects of US-led War on People's Health

The United States has launched wars across the globe. The actual costs of these wars are immeasurable, not to mention its psychosocial impact on human beings. US wars of aggression has massacred millions of civilians and destroyed social infrastructure, including hospitals, schools, marketplaces, water and power systems and office buildings.

Dr. Bert De Belder, Coordinator of Intal/Medical Aid for the Third World (MATW), related during the conference the testimonies of four medical doctors namely: Drs. Geert Van Moorter, Colette Moulart, Harrie Dewitte and Claire Geraets who volunteered for emergency medical aid in Baghdad at the height of the U.S. invasion of Iraq.

"They learned how the water and electricity supply were deliberately targeted by U.S. bombs, inflicting further hardship on the civilian population." De Belder said. "They heard how U.S. troops left wounded Iraqi soldiers to die alongside the road. They were confronted with the dreadful wounds caused by U.S. and British cluster bombs, the use of which in populated areas is prohibited by international law."

Moreover, speaking on developments in Palestine, Dr. Unnikrishnan PV, a delegate from India and spokesperson of Humanitarian Action, said that more than two million people in Palestine are "virtually under house arrest" as a result of US-backed Israeli occupation. A security fence has been built by the Israeli government between the two territories, effectively restricting the movements of Palestinians and violating their right to freely move around. To display their support to Palestinians' quest for independence, health activists attending the conference tore down replicas of the "separation wall" which symbolizes the security fence being built by Israel around Palestine.

Dr. Darby Santiago, Secretary-General of the Health Alliance for Democracy said, "The Arroyo administration, in support of the US President George Bush, has launched its "war against terrorism" targeting patriotic and democratic organizations." Santiago cited the report of KARAPATAN, a human rights organization that stated human and health rights violations. In Southern Mindanao, many have suffered from food blockade (8,413 individuals) and forced

evacuation (4,969 individuals). More than 100,000 civilians were forced to evacuate when the military bombed and strafed victims in Pikit, North Cotabato in Mindanao in Feb. 2003 allegedly in pursuit of members of the kidnap-for-ransom Pentagon gang. Those who flocked to evacuation centers were confronted with lack of food, illness and epidemics causing unnecessary death.

Santiago also mentioned that *hors de combat* (combatants wounded in action) have been summarily executed or tortured. When some are allowed to live, they are imprisoned and deprived of immediate and adequate medical treatment and a doctor of their own choice.

In addition, doctors and health professionals who administer to the needs of the people in situations of armed conflict are themselves harassed and tailed by the military. Offices of health programs are likewise put on surveillance, he said.

Fight for People's Health! Defeat US Imperialism!

“US imperialism is using a whole range of economic, political and military devices to dominate the world. It resorts to “globalization” to tear down other countries’ barriers to exploitation, trade and investment. It uses state terror against the peoples’ of the world through wars of aggression thereby disregarding International Humanitarian Law. The US has waged decades of outright wars in Korea and Vietnam, Afghanistan and Iraq and scores of proxy wars in Latin America, Africa and Southeast Asia,” Santiago highlighted.

In addition, he said, “But peoples of the world continue to resist US imperialism. Wherever the imperialist powers had their official summits, they were besieged by hundreds of thousands of protesters.

“Health activists and advocates have joined in the struggle knowing fully well that health can only be achieved if imperialism and neo-colonialism are defeated and fundamental social change is achieved,” said Santiago.

The challenge that lies ahead

The health workers of today are thus faced with insurmountable challenges that would mean life and death for millions of people worldwide. With enriched spirits and strengthened resolve to work for international solidarity, the delegates to the conference have affirmed not to remain neutral and to add their strength to the broad people’s movement opposing imperialist globalization and impositions and in condemning US-led wars being fought worldwide.

In a unity statement, the participants vowed to support initiatives for strengthening people’s resistance and exploring alternative economic and political systems. They also committed themselves to advance their services and support to and with the suffering and oppressed peoples of the world.

{ USD=53.75 Peso (P) }

THE PACIFIC - Fiji

An effort to improve access to essential medicines and vaccines in the Pacific Island countries

A workshop, sponsored by WHO WPRO, was held in Nadi, Fiji attended by representatives from 18 Pacific Island Nations between 25 - 27 November, 2003. The scene was set with presentations on current global perspectives on access to essential medicines and the current regional vaccine situation. Regional Strategies for Improving Access to Essential Medicines in the Western Pacific Region of the World Health Organization (2004 - 2009) were outlined by Dr. Budiono Santoso, Regional Adviser in pharmaceuticals, WHO) and Mr Truls Eriksen. Experiences from selected countries on access to essential medicines and vaccines in the Pacific Island countries were presented by delegates from those countries.

Bulk Procurement

For many years the Pacific Island Nations have been looking at the possibility of bulk procurement to facilitate access to essential drugs. These nations are constrained by their very limited purchasing power (very small populations), no economy of scale and enormous distances between and within nations. Nevertheless the Fiji Pharmaceutical Bulk Purchase Scheme for Small Island States is being developed. The Facility of the New Fiji Pharmaceutical Services Centre and Future Plan for contributing to Access to Essential Medicines and Vaccines were explained.

Other Issues Associated with Pharmaceuticals

Other issues covered during the workshop included WTO/TRIPS and access to essential medicines, financing of essential medicines and vaccines improving financial planning for medicine supply, medicines supply management and monitoring problems in supplies of essential medicines in the Pacific, framework for Quality Assurance of medicines and practical approach to QA of essential medicines in the Pacific

Vaccine security

Particular attention was directed at issues of vaccine security in the Pacific. Participants shared experiences and were provided with valuable information and resources covering Vaccine Management, effective Vaccine Stores Management Initiative, cold chain store certification, Cold Chain Policy and Management. Vaccine arrival reporting covered a description of the UNICEF Vaccine Arrival report (VAR), a practical exercise to complete a VAR and explanations of simple tests to check vaccine quality (shake test, VVM, CCM, Freeze Watch Monitors).

Recommendations for follow-up activities and initiatives

Group discussions on feasible strategies were conducted and recommendations for collaborative activities to improve access to essential medicines and vaccines were developed.

Information exchange

Information exchange and rapid dissemination of information related to medicines and vaccines to improve the Pharmaceutical and vaccine services is crucial.

An email drug information exchange for Pacific Island countries (DIEFPIC) has been operating for several years. Participants were interested to strengthen this email exchange with the assistance of e-drug. Beverley Snell, HAIAP network partner, was asked to explore the

development of two branches of the discussion through e-drug one open and the other closed. Ms Snell would be the moderator initially and she will train others who are eligible to take over. She would report to the group on the outcome of her discussions.

Procurement issues

The group expressed interest to improve procurement practices to ensure consistency and quality assurance and best value and stable prices. Working groups were formed (Fiji, Tonga, Solomon, PNG, Samoa) to explore regional contracts and continue to strengthen the Small Island States - Fiji Bulk Procurement System. The groups were expected to provide a list of top twenty to fifty by money & by volume, compile tender requirements, look at the Vaccine Initiative model, assist with negotiation of contracts and technical support if required and to provide information on similar schemes.

Human resources

Participants expressed the need for more trained staff. The problems associated with maintaining an adequate workforce were associated with a shortage of appropriately trained pharmacists and locally trained technicians or assistants. In some cases trained pharmacists from other countries were recruited for varying periods. This practice was not ideal because Pharmacy courses in countries like Australia, New Zealand and other 'developed' countries did not cover the concepts and skills needed in the Pacific Island countries. A few pharmacists from these countries had gained good experience in developing countries but they were already working abroad. Pharmacists trained at the Fiji School of Medicine would be ideal. Until their training is completed other measures would need to be considered.

The solutions considered included, formation of working groups to undertake Workforce Planning Development (Marshall Islands, Palau, Fiji, Tonga, Solomon islands) and provision of information on training needs, communicating training needs to existing institutions, exchange of information about existing training programmes, explore the transfer and tailoring of MSH, IDA, INRUD, training materials etc. to the Pacific, explore funding for ongoing courses and training of more assistants by experienced national pharmacists in Pacific Island settings.

A plan to train young pharmacy graduates to help in the interim will be developed by Ms Snell on her return to Australia with the assistance of a small group of pharmacists with international experience and public health training. The plan aims to explore the provision of orientation and training, in accordance with the expressed need of the Small Island States, to appropriate graduates identified through the Victoria Pharmacy College.

Drug regulatory issues

Harmonization of regulations was considered important. To assure quality of medicines in the Pacific, quality control testing at a regional level in both long and short term is needed.

The following immediate actions would take place: Formation of working groups (Tonga, Fiji, Vanuatu) and harmonization of registration requirements and exploration of joint QC testing.

Vaccine Initiative

It was resolved to improve management and function of the Vaccine and Immunization Initiative by:

- Forming a regional group for recommendations to UNICEF
- Forming a distribution centre like the Fiji store
- Going back to countries to discuss taking over responsibility of paying for vaccines and arrange For Cold Chain Management, by January 2005, every country would update their CCM. Recommendations were made:

For every country to perform functional cold chain inventory and look for funding to meet cold chain needs, to establish cold chain training centres, achieve standardization of policies and equipment and agreement to harmonize support, to look into funding to support a cold chain manager and country visits and technical support would be organized as needed.

Ms Snell also prepared a Terms of Reference (TOR) for development of TRIPS compliant, health sensitive legislation and framework in developing countries.

Journal Scan

U.N. Agencies Unveil Ambitious AIDS Treatment Plan

The World Health Organization and the Joint U.N. Program on HIV/AIDS (UNAIDS) marked World AIDS Day by launching a long-awaited campaign, dubbed "3 x 5," to provide 3 million HIV-infected people with antiretroviral drugs by the end of 2005.

A key component of the effort is an innovative generic drug that combines three essential antiretroviral drugs into one pill taken twice a day, Associated Press reported. The pills, manufactured by two India-based generic drug makers and costing patients just \$270 a year, violates patents held by two major drug manufacturers. Countries must suspend the rights of the patent holder to legally import the drugs. **(Chris Tomlinson, AP/Newsday, Dec. 1).**

The pills contain lamivudine, stavudine and nevirapine. Single-pill combinations of antiretrovirals are a major breakthrough for AIDS treatment in poor countries, as they improve the reliability and security of supplies, reduce the number of pills, are easier to take and promote greater patient compliance. They also ensure that the right dosage of each substance is given to the patient, states WHO.

WHO also winnowed down, out of 35 possible combinations of antiretroviral drugs, the four most effective: stavudine, lamivudine and nelfinavir; AZT, lamivudine and nelfinavir; stavudine, lamivudine and efavirenz; and AZT, lamivudine and efavirenz.

According to the WHO, 6 million of the 40 million people who are HIV-positive need immediate retroviral treatment, but only about 480,000 are receiving it **(Lawrence Altman, New York Times, Dec. 1).**

Treating 3 million patients with the drugs by 2005 will cost an estimated \$5.5 billion; therefore, another priority of the 3 x 5 plan is to increase financial aid to poor countries **(Chris Tomlinson, AP/Newsday, Dec. 1).**

On the day before world AIDS Day WHO called on the 34 countries hardest hit by HIV/AIDS to train and organize 100,000 health care and nonprofessional workers to help achieve its goal of delivering the drugs. The plan calls for expanding existing programmes to train workers and improve services, not adding new ones. But even if the program is a success, insufficient drug supplies will mean countries will have to face enormous ethical issues in deciding whom to treat.

"The question of who will receive antiretroviral drugs is really a question of who shall live," said Julian Fleet, a Senior Policy Adviser on HIV/AIDS **(Lawrence Altman, New York Times, Dec. 1).**

To commemorate World AIDS Day, U.N. Secretary General Kofi Annan issued a statement urging the world to join him in "tearing down the walls of silence, stigma and discrimination that surround the epidemic." "No progress will be achieved by being timid, refusing to face unpleasant facts, or prejudging our fellow human beings — still less by stigmatizing people living with HIV/AIDS" (**Economic Commission for Latin America and the Caribbean release, Dec. 1**).

Source: UN Wire, 1 December 2003 (Copyright National Journal Group Year). For more information on this subject visit www.unfoundation.org

Do Medications Really Expire? by Richard Altschuler

Does the expiration date on a bottle of a medication mean anything? If a bottle of Tylenol, for example, says something like "Do not use after June 1998," and it is August 2002, should you take the Tylenol? Should you discard it? Can you get hurt if you take it? Will it simply have lost its potency and do you no good?

In other words, are drug manufacturers being honest with us when they put an expiration date on their medications, or is the practice of dating just another drug industry scam, to get us to buy new medications when the old ones that purportedly have "expired" are still perfectly good?

The following information was retrieved from medical databases and general literature.

- First, the expiration date, required by law in the United States, beginning in 1979, specifies only the date the manufacturer guarantees the full potency and safety of the drug - it does not mean how long the drug is actually "good" or safe to use.

- Second, medical authorities uniformly say it is safe to take drugs past their expiration date - no matter how "expired" the drugs purportedly are. Except for possibly the rarest of exceptions, you won't get hurt and you certainly won't get killed. A contested example of a rare exception is a case of renal tubular damage purportedly caused by expired tetracycline (**reported by G. W. Frimpter et al., in the Journal of the American Medical Association, JAMA, 184:111, 1963**). This outcome (disputed by other scientists) was supposedly caused by a chemical transformation of the active ingredient.

-Third, studies show that expired drugs may lose some of their potency over time, from as little as 5 per cent or less to 50 percent or more (though usually much less than the latter). Even 10 years after the "expiration date", most drugs have a good deal of their original potency. So wisdom dictates that if your life does depend on an expired drug, and you must have 100 percent or so of its original strength, you should probably toss it and get a refill, in accordance with the cliché, "better safe than sorry." If your life does not depend on an expired drug - such as that for headache, hay fever, or menstrual cramps - take it and see what happens.

One of the largest studies ever conducted that supports the above points about "expired drug" labeling was done by the U.S. military 15 years ago, according to a feature story in the Wall Street Journal (**March 29, 2000**), reported by Laurie P. Cohen. The military was sitting on a \$1 billion stockpile of drugs and facing the daunting process of destroying and replacing its supply every two to three years, so it began a testing program to see if it could extend the life of its inventory. The testing, conducted by the U.S. Food and Drug Administration, ultimately covered more than 100 drugs, prescription and over-the-counter. The results showed that about 90 per cent of them were safe and effective as far as 15 years past their original expiration date.

In light of these results, a former Director of the testing program, Francis Flaherty, said he concluded that expiration dates put on by manufacturers typically have no bearing on whether a drug is usable for longer periods. Mr. Flaherty noted that a drug maker is required to prove only that a drug is still good on whatever expiration date the company chooses to set. The expiration date doesn't mean, or even suggest, that the drug will stop being effective after that, nor that it will become harmful. "Manufacturers put expiration dates on for marketing, rather than scientific, reasons," said Mr. Flaherty. "It is not profitable for them to have products on a shelf for ten years. They want turnover."

The FDA cautioned there is not enough evidence from the program, which is weighted towards drugs used during combat, to conclude most drugs in consumers' medicine cabinets are potent beyond the expiration date. Joel Davis, however, a former FDA expiration-date compliance chief, said that with a handful of exceptions - notably nitroglycerin, insulin and some liquid antibiotics - most drugs are probably as durable as those the agency has tested for the military. "Most drugs degrade very slowly," he said. "In all likelihood, you can take a product you have at home and keep it for many years, especially if it's in the refrigerator." Consider aspirin. Bayer AG puts two-year or three-year dates on aspirin and says that it should be discarded after that. However, Chris Allen, a Vice President at the Bayer unit that makes aspirin, said the dating is "pretty conservative;" when Bayer has tested four-year-old aspirin, it remained 100% effective, he said. So why doesn't Bayer set a four-year expiration date? Because the company often changes packaging, and it undertakes "continuous improvement programs," Mr. Allen said. Each change triggers a need for more expiration-date testing, and testing each time for a four-year life would be impractical. Bayer has never tested aspirin beyond four years, Mr. Allen said. But Jens Carstensen has. Dr. Carstensen, Professor Emeritus at the University of Wisconsin's pharmacy school, who wrote what is considered the main text on drug stability, said, "I did a study of different aspirins, and after five years, Bayer was still excellent. Aspirin, if made correctly, is very stable.

Source: Posted on the PHA Exchange on 16 December 2003

Comment:

The article by Altschuler raises an important issue, with potential impact on public health. Artificial shortening of medicines shelf-life increases costs of medications, not only for the consumer, but also for purchasing and distribution systems. This is particularly important for expensive essential medicines, such as antiretrovirals, artemether derivatives, medicines for resistant tuberculosis, a number of antibiotics, and medicines for cardiovascular prevention and treatment, cancer chemotherapeutic agents, etc.

Therefore, there is a need for long-term studies on medicines expiration from each manufacturer. WHO and other international agencies and organizations should prompt pharmaceutical manufacturers, either of the original product or of a generic version, to provide all available information on long term stability studies and to undertake these studies with all their products, in particular those deemed essential and of high cost.

By Joan Ramon Laporte - Professor of Clinical Pharmacology at the Autonomous University of Barcelona, Director, Catalan Institute of Pharmacology

U.S. Prescription Drug System Under Attack

For half a century Americans could boast of the world's safest, most tightly regulated system for distributing prescription drugs. But now that system is undercut by a growing illegal trade in pharmaceuticals, fed by criminal profiteers, unscrupulous wholesalers, rogue Internet sites and foreign pharmacies.

In the past few years, middlemen have siphoned off growing numbers of popular and lifesaving drugs and diverted them into a multibillion-dollar shadow market. Crooks have introduced counterfeit pharmaceuticals into the mainstream drug chain. Fast-moving operators have hawked millions of doses of narcotics over the Internet. The result too often is pharmaceutical roulette for millions of unsuspecting Americans. Cancer patients receive watered-down drugs. Teenagers overdose on narcotics ordered online. AIDS clinics get fake HIV medicines.

The shadow market exploits gaps in state and federal regulations to corrupt this system, creating a wide-open drug bazaar that endangers public health. A year long investigation by The Washington Post has found: Networks of middlemen, felons and other opportunists operating out of storefronts and garages fraudulently obtain deeply discounted medicines intended for nursing homes and hospices. The diverters have stored drugs in U-Hauls and car trunks in blazing heat, stuffed them in plastic sandwich bags and traded them in a daisy chain of transactions with no purpose except to enrich the traders. Those drugs are ultimately sold to unwitting patients.

* The diverters pave the way for counterfeiters who use pill-punching machines and special links to produce near-perfect copies of the most popular and expensive drugs. Some fakes have passed undetected through wholesalers to the shelves of retail pharmacies.

* Pharmaceutical peddlars take advantage of lax regulations to move millions of prescription drugs into the United States from Canada, Mexico and elsewhere. Overwhelmed customs' workers inspect less than 1 per cent of an estimated 2 million packages containing medicine shipped into the country each year. Virtually all of those shipments are illegal, yet the Food and Drug Administration fails to enforce its own import regulations, saying it lacks the resources to intercept the illegal packages.

* Rogue medical merchants set up Internet pharmacies that serve as pipelines for narcotics, selling to drug abusers and others who never see doctors in person or undergo tests. Scores of customers have become addicted, overdosed or died.

The shadow market, which includes both legal and illegal operators, has grown rapidly yet received little public attention. Isolated problems nationwide have attracted the interest of some state and federal prosecutors and resulted in lawsuits. But the increasing recalls of tainted medicines, overdoses on Internet-bought drugs and cross-border pharmaceutical trade are part of a larger pattern. Taken together, the worst elements of the shadow market constitute a new form of organized crime that now threatens public health.

The shadow market takes advantage of technology, global trade, vast disparities in pharmaceutical prices, the explosive growth of enticing new miracle drugs and the self-medicating habits of an aging baby-boom population. It extends from small, backroom operations to buck-raking Internet pharmacies to the warehouses of the nation's largest drug distributors.

Diverters reap millions illegally by buying drugs at a discount to sell to secondary wholesalers. In some cases, the drugs have turned out to be diverted, diluted or counterfeited. The growth of the shadow market comes as Americans are spending more money than ever on prescription drugs. Between 1994 and 2001, the number of prescriptions swelled to 3.1 billion -- a nearly 50 percent increase. In nearly the same period, sales soared from \$61 billion to \$155 billion.

Often, fraudulent closed-door pharmacies consist of little more than a desk, a fax machine and a few shelves. Yet they place excessively large orders with drug manufacturers.

The diverters take the discounted drugs, mark up the prices and rapidly move them to small wholesalers who add another markup and sell to other wholesalers. In some cases, pharmaceuticals may change hands six or more times, going from state to state.

No one knows how big the drug diversion market is. State and federal investigators say losses easily amount to billions of dollars annually. Many licenses, few inspectors existing laws and regulations present few barriers entry into the wholesale drug market.

It can be harder to become licensed as a beautician than as a pharmaceutical distributor. "The problem is, just about anybody can get a license. Nationwide, there are an estimated 6,500 small wholesalers, yet most states have only a handful of inspectors. In some states, amusement park rides, elevators and even dog kennels are inspected more frequently than drug wholesalers. In 1988, Congress attempted to stop diverters by passing the Prescription Drug Marketing Act. The law required that wholesalers provide a piece of paper - similar to a car title -- disclosing all prior sales. The paper trail, known as a pedigree, would allow each wholesaler to verify they were buying from reputable sources.

But wholesalers objected to what they deemed to be burdensome paperwork and said the new law would drive some smaller wholesalers out of business.

Source: Originally written by Gilbert M Gaul and Mary Flaherty for the Washington Post. Posted on the PHA Exchange on 21 Oct 2003

Inequality in Latin America and the Caribbean: Breaking with History?

To break with the long history of inequality in Latin America and the Caribbean, societies need to undertake deep reforms of political, social and economic institutions, improve access by the poor to vital services and assets - especially education - deliver income transfers to poor families, and adopt specific policies to help indigenous people and Afro-descendants, a new World Bank study says.

Inequality in Latin America and the Caribbean: Breaking with History? released in Mexico city, explores why the region suffers from such persistent inequality, identifies how it hampers development, and suggests ways to achieve greater equity in the distribution of wealth, incomes and opportunities.

"Latin America and the Caribbean is one of the regions of the world with the greatest inequality," said David de Ferranti, World Bank Vice President for Latin America and the Caribbean who, with Guillermo Perry, Francisco H.G. Ferreira and Michael Walton, guided the team that produced the report. "Latin America is highly unequal with respect to incomes, and also exhibits unequal access to education, health, water and electricity, as well as huge disparities in voice, assets and opportunities. This inequality slows the pace of poverty reduction, and undermines the development process itself."

The richest one-tenth of the population of Latin America and the Caribbean earn 48 percent of total income, while the poorest tenth earn only 1.6 percent, the research team found. In industrialized countries, by contrast, the top tenth receive 29.1 percent, while the bottom tenth earn 2.5 percent.

Using the "Gini Index" of inequality in the distribution of income and consumption, the researchers found that Latin America and the Caribbean, from the 1970s through the 1990s, measured nearly 10 points more unequal than Asia, 17.5 points more unequal than the 30 countries in the Organization for Economic Cooperation and Development, and 20.4 points more unequal than Eastern Europe.

The data show that inequality in the least unequal Latin American Country (LAC) - Uruguay - is higher than in the most unequal country in Eastern Europe and the industrialized countries. On average, income inequality has tended to worsen slightly in the region, though experiences have varied. Some relatively equal countries, including Argentina, Uruguay and Venezuela have experienced rises in inequality- Argentina dramatically so. By contrast Brazil, historically the most unequal country in the region, experienced a modest, but significant improvement. Mexico may also have enjoyed a small improvement.

The report singles out race and ethnicity as enduring determinants of one's opportunities and welfare in Latin America. Indigenous and Afro-descended people are "at a considerable disadvantage with respect to whites," the report says, with the latter earning the highest wages in the region. Focusing on seven countries - Brazil, Guyana, Guatemala, Bolivia, Chile, Mexico and Peru - the study found that indigenous men earn 35-65 per cent less than white men. The disparity between white women and non-white women was in the same range. In Brazil, men and women of African descent earn about 45 percent of the wages of their white counterparts.

In Guatemala, Bolivia and Brazil, three countries where ethnic and racial categories are significant, over 50 per cent of households headed by white men or women have access to sewerage as compared to 30 per cent of those headed by indigenous men and 37 per cent for those headed by indigenous women. Across the region, citizens who are both female and of indigenous or African descent are at the bottom of all asset-distribution scales.

In contrast to enduring gaps correlated to racial and ethnic differences, Latin America has experienced progress in narrowing gender differentials in income and education. In much of the region, girls and young women are actually overtaking boys and young men in educational attainment.

Inequality is as deeply rooted as it is complex. The World Bank's research team drew data from 20 countries based on household surveys covering 3.6 million people, and reviewed extensive economic, sociological and political science studies on inequality in Latin America. The team found that the unequal distribution of resources that characterizes the region today follows a pattern set with specific traits of European colonization in the region.

In modern times as in the early colonial periods, elite populations shaped institutions and policies to serve their interests first, the report found. For instance, most LAC countries did not achieve high levels of literacy until well into the 20th century. Low levels of support for basic education contrasted with generous financing for universities, where the children of the elite were trained. Political institutions in the region, typically, have been weak. And while transitions to democracy have brought valuable gains, patterns of influence remain highly unequal, with traditions of clientelism and patronage often continuing despite national and local elections.

In a global economy, where "human capital" is critical to competitiveness, inequalities which result in a failure to develop people's skills and knowledge to optimum levels, among other factors, can actually slow down the rate of economic growth, and weaken the poverty-reducing impact of the growth that does occur.

To address the deep historical roots of inequality in Latin America, and the powerful contemporary economic, political and social mechanisms that sustain it, the report outlines four broad areas for action by governments and civil society groups to build coalitions to break this destructive pattern.

Build more open political and social institutions that allow the poor and historically subordinate groups, such as Afro-descendants and indigenous people, to gain a greater share of agency, voice and power in society. Ensure that economic institutions and policies seek greater equity, through sound macroeconomic management and equitable, efficient crisis resolution institutions that avoid the large regressive redistributions that occur during crises, and that allow for saving in good times to enhance access by the poor to social safety nets in bad times.

Increase access by the poor to high-quality public services, especially education, health, water and electricity, as well as access to farmland and the rural services the poor need to make it productive. Protect and enforce the property rights of the urban poor.

Reform income transfer programs so that they reach the poorest families, including use of measures that are conditional on keeping children in school and attending health services, so as to improve their lifelong income-earning capacity.

"The key to reducing inequality in Latin America is institutional reform," said Guillermo Perry, the Bank's Chief Economist for Latin America and the Caribbean, and co-author of the study. "To overcome the inequality that undermines their efforts to get out of poverty, poor people must gain influence within political and social institutions, including educational, health and public services institutions. To enable them to achieve such influence, the institutions must be truly open, transparent, democratic, participatory - and strong."

Perry and fellow research team leaders Francisco H. G. Ferreira and Michael Walton concluded that success in "breaking with the long history of inequality in Latin America" depends on "strong leadership and broad coalitions" to achieve progress in the first area for action, namely to mobilize "the political agency of progressive governments and the poor."

Finally, the report calls for reform of Latin America's "truncated, elitist welfare state", so that social security and social assistance actually reach the poor and households dependent on the informal sector. In addressing this complex agenda, the report focuses on a specific set of measures as an illustration of what is possible. For example, targeted income transfers conditioned on keeping children in school and attending health services could be an important part of a more equitable welfare state. In making the case for expanded use of conditional cash transfers, the research team cites as examples of success programs such as those underway in Mexico, Brazil and Nicaragua.

Mexico's "Oportunidades" (formerly PROGRESA) program helps poor families finance educational and health costs, and Brazil's "Programa Nacional de Bolsa Escola," and "Programa Bolsa Alimentação," offer education and nutrition subsidies, respectively. Results from Mexico, where Oportunidades covered 4.2 million rural and urban families at the end of 2002, show enrolments in middle schools increasing from 67 percent to about 75 percent for girls, and from 73 percent to about 78 percent for boys as a consequence of the program. Health and nutrition results are even more striking. Height growth among infants in the crucial 12-36-month range

increased by about 1 cm per year - in an environment in which the incidence of stunting was at 44 percent of the infant population before the program began. And, as a result of increased visits to medical providers, illness among newborns decreased by 25 per cent, among infants aged under two by 19 per cent and among children aged three to five by 22 per cent...."

Source: PHA Exchange

India to supply free drugs to HIV-positive

The Government plans to supply free drugs to those infected with HIV/AIDS virus and need anti-retroviral treatment and to introduce legislation to tackle all aspects of the disease, including discrimination faced by HIV-positive people.

Health Minister Sushma Swaraj announced the proposals on the eve of World AIDS Day, saying the Rs 2 billion programme to supply anti-retroviral drugs would be implemented from April 2004 in six states with the highest prevalence of HIV/AIDS. The six states are Nagaland and Manipur in the Northeast, Andhra Pradesh, Karnataka and Tamil Nadu in the South and Maharashtra, the nation's most industrialised Western state. The project would cover 100,000 people in its first year, Swaraj said.

The new law, likely to be introduced in the budget session of Parliament, would make discrimination against HIV positive people and the refusal by hospitals to treat them an offence, she further stated. Swaraj and Senior Officials, said the overall rate of increase in HIV infections across the country was "plateauing".

Swaraj said the new initiative to supply anti-retroviral drugs in six states would "go a long way in fighting this deadly disease that is targeting our youth".

"We are moving from a uni-focal to a holistic approach in tackling AIDS. Earlier, our programmes were prevention-centric. Now we have added the element of care and support," she said.

Swaraj, however, admitted the stigma associated with HIV continued to be a problem. "The removal of this stigma is a focus area. This is a shortcoming due to lack of awareness. When even doctors refuse to treat AIDS patients, this stigma increases," she said.

Health Ministry Officials said a group headed by Health Secretary J.V.R. Prasada Rao was talking to pharmaceutical firms to supply daily doses of anti-retroviral drugs for less than 39 cents, the price at which some Indian firms have agreed to sell the medicines to the foundation headed by former US President Bill Clinton that is spearheading a major campaign to make available AIDS treatment at low costs. The pharmaceutical firms have, in turn, sought the same fiscal incentives that are provided to them for exports, the officials said. Under the Rs 2 billion programme, the Health Ministry will provide Rs.1.13 billion for supplying the drugs free while the rest will be spent on sophisticated equipment to monitor the status of people taking the drugs.

Swaraj said the Finance Ministry had been asked to make a separate allocation in the Health Ministry's budget for the free drugs programme so that it could be sustained. The new AIDS law, which was being framed with the help of the Law Ministry, would cover care and support, measures to curb discrimination and the prevalence of quacks and blood safety, she said.

"Under this law, matters like doctors refusing treatment to HIV positive people or HIV positive children being refused admission to schools will be made offences," she said. In recent years, India has emerged as one of the largest suppliers of cheap anti-retroviral drugs. Besides the Clinton Foundation, Indian pharmaceutical companies have signed contracts to supply the drugs to countries in Africa and the Caribbean.

Source: Originally from the Indo-Asian News Service, New Delhi posted on the PHA Exchange, 1 December 2003

Glaxo to face AIDS lawsuit

Pharmaceutical giant GlaxoSmithKline (GSK) is to be the subject of a 1 billion Rand class action suit following the South African Competition Commission's (CC), recent ruling against the British company.

American NGO Aids Healthcare Foundation President Michael Weinstein said the CC ruled that millions had been denied access to AIDs medication both because of the high cost of GSK branded products and because of the company's refusal to grant other companies the licence to manufacture cheaper generic versions of the desperately needed drugs.

"The GSK product brochure says 'The Key is Sustainability' but the primary obstacle to sustainability is the high price which is being illegally maintained by GSK," he said.

Weinstein said he anticipated a large sum being awarded but called on GSK, in the interests of reconciliation and of the future, to establish a R1bn fund of free AIDs drugs for South Africa.

Strauss Daly Inc Attorney Musa Ntsibande, who handled the CC case and who will be handling the suit, said the gist of the claim was that GSK abused its dominant position in the market by maintaining excessive prices which placed them out of the reach of the people who most needed them.

"The Competition Commission vindicated our complaint that GSK violated laws which prohibit dominant firms from excessive pricing to the detriment of consumers. They also did not give access to the patents of critical drugs to their competitors when it was economically feasible to do so," said Ntsibande.

Swazi Hlubi, Executive Director of the Network of Aids Communities of SA (NetComSA), said it was impossible to put a price on the suffering and deaths of millions in South Africa of AIDs.

"Now that our Competition Commission has found GSK guilty, the weight of many of these deaths and the ongoing pain and suffering of those who cannot access medication falls squarely on GSK. We invite any patients and family members harmed by GSK's policies to consider joining us in this joint action against GSK," she said.

"This joint action law suit against GSK will seek the awarding of damages by the courts to patients or dependants who lost breadwinners to AIDs who, because of excessive pricing by GSK, were not able to access treatment.

"With that in mind, we ask GSK now to do the right thing and set aside R1bn and earmark the sum for free AIDs treatment here in South Africa," said Ntsibande

Source: Originally written by Zoubair Ayoob for the New York Times. Posted on IP Health on 17 November 2003

Resources

PATHOLOGIES OF POWER: Health, Human Rights, and the new war on the poor

Paul Farmer, with a foreword by Amartya Sen

*University of California Press, Berkeley and Los Angeles, 2003.,
402 pp, U\$27.50.*

Although Dr Paul Farmer 's latest book does not really talk about a 'new' war on the poor, but rather an ancient one, the author has the full moral authority to write this book. In vivid case studies from both the North and the South, Farmer shares with us his experiences with the violation of human rights. The case studies may be depressive, but overall, they convey a message of optimism. The book not only searches for, analyzes and explains the social causes of structural violence and extreme suffering, but it also explores and deplors our collective tolerance of the social aberrations. The book centers around a well documented critique of the liberal views on human rights, which have rarely served the interests of the poor.

Farmer advances many and varied loosely-bound theses among which the following are worth sharing:

On Power: The asymmetry of power generates in many forms of quiet brutality. The inequities of power that prevent the poor from accessing the opportunities they need to move out of poverty. So, the 'pathologies of power' take their toll --including a toll in human lives. Denying this only serves the interests of the powerful; a change of mentality is needed in the hearts and minds of those with power. Structures and not just individuals must be changed if the world is to change.

On Inequity: It is social and economic inequalities that deny services to the poor. The promotion of equity is the central ingredient for respecting human rights in health; this, at a time when the prevailing dogma calls for projects to be 'self-sustaining' and 'cost-effective'. Cost-effectiveness may be relevant, but does not reduce inequity.

On the poor: The poor are not the casual victims of human history; poverty results from the actions of other human beings, the result of man-made structural violations. For instance, the majority of ethnic minorities are poor; in the literature, their race is used as a substitute for class, but their plight is the result of the ongoing process of oppression. The poor are not begging, they are demanding a right they have earned.

On Poverty: Poverty, part and parcel of the global free-market system, is the world's greatest killer. It is not enough to improve the situation of the poor within the existing social relationships. Poverty of the poor demands that we build a different, more just social order.

On Public Health: The right to health is perhaps the least contested social right and yet the poor bear the brunt of both preventable ill-health and human rights violations. Health advocacy has failed miserably. Somehow, public health must be linked to a return to social justice. With no access to treatment, pneumonia or TB is more lethal than AIDS; the discoveries of Salk, Sabin and even Pasteur remain irrelevant to much of humanity. Poverty puts people at risk, but bars them from access to effective treatment because denial of care to those who do not pay is legitimized in the free market system. We are at a cross-road: Health care can be a commodity to be sold or it can be considered a basic social right; it cannot be both. Ergo, equity also is the central challenge for the future of public health. The author even speaks of the 'pathogenic role of inequity' and hence of a 'right to equity'.

On Ethics: Relaxed ethical practices are unacceptable. However, without a social justice component, medical ethics risks become yet another strategy for managing inequality. Conventional medical ethics are concerned with the ethics of the individual; it is quite divorced from the tangible social reality. Social and economic rights are at the heart of what must become the new medical ethics; we need an ethics of distributive justice.

On Solutions Attempted: It is totally unacceptable to attempt a differential valuation of human life. Only by including social and economic rights in the struggle for human rights, can we protect those most likely to suffer the insults of structural violence. This is part and parcel of offering a more viable direction for future action. But ultimately, the real energy to find workable solutions can only come from the oppressed themselves.

In conclusion, Farmer makes six suggestions; they are to:

* Make health and healing the symbolic core of the agenda: He calls for engaging health professionals in human rights work so as to ensure health for all and to decrease health inequalities.

* Make the provision of services central to the agenda: He asks the readers to listen to the abused when providing services; to distribute interventions equitably; to closely work with community-based organizations to improve access. He reminds us that the states are best placed to protect the basic rights of poor people; that the state failure cannot be rectified by human rights activism by NGOs; that the search for (economic) sustainability is often at odds with social justice approaches to health; that efficiency cannot trump equity in the field of health and human rights.

* Establish new research agendas: He thinks we need to examine why some populations are at risk and others are spared human rights violations. Farmer fittingly reminds us, however, that research should remain secondary and be designed to improve services and social justice.

* Assume a broader educational mandate: Do not preach only to the converted, he tells us; also, do not try to teach lessons to recalcitrant governments and reluctant international agencies; simply more education will not do for them.

* Achieve independence from powerful governments and bureaucracies: A central irony of human rights law, he reminds us, is that it consists largely of appeals to the perpetrators; collaboration with communities in resisting ongoing violations of human rights is the way to go. And finally,

* Secure more resources for health and human rights: States have become less able to help their citizens attain social and economic rights even though they have most often retained their ability to violate these rights. It is easy to demand more resources, what is hard is to produce them.

The author concedes his book is principled, but extreme. It is not harsh though; the realities it describes are; the crimes it unveils are predictable and ongoing. What all the victims have in common and share is poverty and an unwillingness to knuckle under. Pathologies of power damage everybody, but kill chiefly the poor. We cannot, therefore, stay in our comfort and innocence.

In closing, Farmer tells us that if we lack the ambition to do what is needed, we should expect the next 50 years to yield a harvest of shame. In the Afterword, Dr Farmer asks why we should give a damn? And the 'because' is loud and clear: It is not useless to complain! You've got to read the book to see if you agree.

To order a copy please visit www.amazon.com

'Health and Human Rights Readers'

by Claudio Schuftan

Pgs. vi +111, Paperback

Price Rs. 80 / \$5/ £4 (Please add postage per copy - Within India: Rs. 20 / International postage: \$2)

Centre for Enquiry into Health and Allied Themes (CEHAT) has recently published the book 'Health and Human Rights Readers' authored by Dr. Claudio Schuftan, an internationally known Public Health expert and health activist associated with the People's Health Movement.

This book is a compilation of fifty-two 'Readers in Human Rights', essays which have been previously circulated by Claudio on various electronic list-servers, some of the more recent Readers having been circulated on the PHA-exchange. The goal underlying the Readers, in Claudio's words, is "to re-center the development debate, and to convincingly articulate the reasons for centering it around human rights. The readers give you food for thought and for action for just that."

The Readers discuss a wide range of issues such as Human Rights based planning; the role of the State, UN and civil society; Health sector reform and the unmet needs of the poor; Health Care Financing; vulnerability, access and discrimination; the role of NGOs; globalization, health rights and health sector reform; the right to adequate nutrition; the difference between project and process; and health rights and the law.

These informative yet provoking readers would appeal particularly to health activists, health professionals and health sector NGO workers who seek a clearer grasp of health rights and a stimulating guide to action.

Here Claudio squarely places Human Rights concerns at the centre of all health work, and gives the call for "a start-over, a global movement, a grassroot revolution around the right to health."

To request for copies contact CEHAT, Survey No. 2804 and 2805, Aram Society Road, Vakola, Santacruz (East), Mumbai 400055, India, cehat@vsnl.com or CEHAT, Flat No. 3&4 Aman Terrace Plot No. 140, Dahanukar Colony, Kothrud, Pune 411029, India, cehatpun@vsnl.com

WHO's World health Report 2003 – *Shaping the future*

Published by the World Health Organization

140 pgs

15 Swiss francs/US\$13.50

In developing countries Sw. Fr. 10.50

Order No. 1242003

On 18 December 2003 – the World Health Organization (WHO) launched the World Health Report 2003 - Shaping the future, highlighting the urgent need for investment and international support to strengthen the ailing health care systems of most developing countries.

This report predicts that the next few years will witness major global health improvements. It affirms that the key task of the global health community is to close the gap between social inequities. Real progress in health to this regard, depends vitally on stronger health systems based on primary health care. 'Shaping the future' is actually going back to the basics, that is building on the values and practices of primary health care, the core principles of which remain as relevant in 2003 as they did at Alma Ata in 1978.

It argues that the key to success is the reinforcement of the health systems and the construction and development of responses that support integrated long term health systems on behalf of the entire population. As Dr. Lee Jong Wook, Director-General of the WHO stated, "sustained effort, increased resource commitments and intensified collaboration among partners will be required. WHO is now making results in countries its main objective. Effective action to improve population health is possible in every country but it takes local knowledge and strength to turn that possibility into reality". Thus success will demand new forms of cooperation between international health agencies, national health leaders, health workers and communities and other relevant sectors.

The report is refreshing in its attempt to offer an integrated approach in improving health. It consists of seven chapters titled:

* Global Health: today's challenges, * Millennium Health Goals: paths to the future, * HIV/AIDS: confronting a killer, * Polio Eradication: the final challenge, * SARS: lessons from a new disease, * Neglected Global Epidemics: three growing threats and * Health Systems: principled integrated care

The report opens with an update of the current state of health in the world. Reviewing the latest global health trends, chapter one finds disturbing evidence of widening gaps in health worldwide. In 2002, while life expectancy at birth reached 78 years for women in developed countries, it fell back to less than 46 years for men in the Sub-Saharan Africa mainly because of the HIV/AIDS epidemic. For millions of children today, particularly in Africa the biggest health challenge is to survive until their fifth birthday and their chances of doing so is less than they were a decade ago. This is the result of a continuous impact of communicable diseases. However, the simultaneous occurrence of increased non-communicable diseases globally adds to the daunting challenges which already face many developing countries.

Chapter two traces the origin of the millennium development goals and charts the progress towards achieving them so far. Three of the eight goals are directly health related; all of the others have important indirect effects on health. This chapter shows that there is much that can be done to accelerate progress. It is possible to scale up efforts to confront the AIDS pandemic, to reduce the risk of death in child birth, to ensure the survival of children and to strengthen the health infrastructure needed for gains towards the MDGs and other health objectives.

The next chapter describes how HIV/AIDS has changed the world – Sub-Saharan Africa in particular – during the last two decades, why it now represents a global emergency and how it can be brought under control. It suggests an aggressive strategy for global action against the HIV/AIDS pandemic that unites the efforts of WHO and its partners from many sectors and effectively combines prevention and care.

Chapter four deals with an encouraging story of how a major ancient disease has almost been conquered. As a result of the global polio eradication initiative, one of the largest public health efforts in history, the number of children paralyzed by this devastating disease every year has fallen from over 3,50,000 in 1988 to about 1900 in 2003, the number of countries in which the disease is endemic has fallen from 125 to seven. The vision of a polio free world is now within our reach.

Chapter Five is the story of the brief but deadly encounter with one of the world's latest threats, SARS – how a vital victory was achieved and the lessons it offers for the future. Seven clear lessons emerge from the SARS epidemic and will help shape the future of infectious disease control. Confronting the double burden is the theme of Chapter Six. A deadly overlap between communicable and non-communicable diseases and injuries is occurring throughout the developing world leading to a crisis of priorities for health systems already struggling with inadequate resources. The chapter also examines the stealthy but rapid evolution of two epidemics – tobacco related diseases and hidden epidemic of road traffic casualties and traffic related environmental hazards. Health systems must be strengthened to meet the formidable challenges described in the previous chapters.

Chapter Seven tackles the issue of stronger health facilities in depth. Reinforced cooperation with countries to scale up health systems is part of WHO's new way of working. Strengthening the organizations presence and technical collaboration in countries is the best way for WHO to speed progress towards the global health communities' most important goals: measurable health improvement for all and aggressive strides to close equity gaps. The purpose of this World Health Report is to encourage action for health improvements especially for the poor and disadvantaged. This is no longer time for academic debate: the moral imperative is for urgent action.

“Shaping the future” requires strengthening of foundations. The report asks from the world health community to focus on supporting the health systems which form the foundations for medical intervention.

“I urge the global community to set its sights on bold objectives”

Director-general WHO

Reviewed by Emmanuel S. Gnanamanickam

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