

Solidary Health Care Financing

Realizing the Right to Health for All needs structures that enables people to realize their health rights and achieve the best health status possible – these wider context is framed by the social determinants of health. Only in addressing this wider context of equitable resources and chances for people we can think of reducing health inequities.

In addition to these fundamental conditions a system of protection measures is needed that people have access to in case of ill-health. This important concretisation of the “Right to health” is the “Right to health care”

The debate about a “public responsibility” for the provision of such a “social infrastructure” is heated, even if the “right to health” has entered mainstream political discourse: a good example is the recent controversies in the US about the introduction of a universal social health protection mechanism in form of a “public insurance option”

Looking into this from a historical point of view, moral arguments of “social responsibilities” could materialize in expanding access to social and health care mostly in times of societal conflict and transformations: In continental Europe in the late 19. Century in the escalating conflict between the organized workers movement and the capital interests, collective and solidary insurance models first developed within traditional craft trades and guilds, could be expanded to the new proletarian classes in the thriving industry. In post-WW2 – England the introduction of the National Health Service could find a political majority.

Also in the self liberating colonies the creation of public, accessible health care services were a highly symbolic break with the services provided to colonialists and elites only.

But this promise of “health care for all” in the developing countries was massively hampered by limited own resources of the own “underdeveloped” economies, enforced by colonial and post-colonial economies of trade until today

The concept of a “sustainable financing” of social services became under the enforcement of international finance institutions Worldbank and IMF a blueprint for the dismantling of a “social infrastructure” through reduced public spending and the replacement by out of pocket spending of patients and an unregulated private health care market, putting people all too often for the dire decision of health or economic bankruptcy: catastrophic health expenses are driving 100.000 Families annually into debt and misery.

In the poorest countries, less than 10 USD are available in the public health sector per person and year, not only abysmal in comparison with 3000-8000 USD health care costs in industrialized countries, but also far from any calculated “basic package of care”.

A decaying, neglected infrastructure, an overworked and underpaid staff, that looks out and is lured away for work-migration into richer countries, combined with unofficial or official out of pocket payments make the public sector an easy prey of the neoliberals criticizing the insufficient public sector.

Given these realities, to opt for isolated “national” financing concepts would render the right to health, that can be a human right only for all or for nobody, absurd.

As economic profit in a globalized economy is increasingly escaping the place of origin and cannot any longer be taxed for a “national solidary financing”, the financing mechanisms of a global social infrastructure need to be globalized as well, Only with this, realizing the Right to health for all people in all places of the world can become a reality.

An important breach into the “dogma of sustainability”, that had led to the massive under financing of public health care in the developing countries, was the result of the pressure of the international AIDS treatment campaigns in 2001.

The international community agreed on a sustained financing of the costs for the three most important epidemics, HIV/AIDS, Malaria and Tuberculosis. The resources for the prevention, treatment and care in specific programmes, channelled through the Global Fund to Fight HIV/AIDS, Tb and Malaria and other bilateral programmes as the US programme PEPFAR.

But - the Problems with this approach are increasingly visible, and make a further expansion and radicalisation of the concept necessary: The contribution to these programmes are still voluntary and a high amount of regular fundraising among the still most important OECD-donor countries is needed, escalating around the “replenishments meetings” with all problems of competition between programmes and funding instruments.

A mandatory, solidary solution is therefore necessary to assure the continuity of the financial transfers, to make a reliable financing possible.

Second – the disease specific programmes need always an existing health infrastructure to implement them; is this missing, and in many of the poorest countries this is exactly the case, the reach out of the programmes are limited and rather deepen the gap between the people with better access to health care and the ones without, aggravating the situation of inequitable.

Or – the specific programmes build parallel systems and increasing the gap between people with “privileged diseases” and others, who are suffering and dying from “ordinary diseases” – be it missing obstetric care, infant pneumonia, Diabetes, Asthma or cancer.

A systematic expansion of a solidary global health financing mechanism needs to strengthen the health infrastructure, in addition to the specific disease programmes, this is a precondition to realize “access for All” and the Right to health care.

Third – an important point remains the questions how the health systems should look like that are supported by these resources – the debates on

public and private health services, revived in the last year by Oxfam's important report "Blind Optimism Challenging the myths about private health care in poor countries" show this very clearly. Even if Public-private partnerships have lost a bit the miracle solution touch they had ten years ago, the advocates for private solutions are still very active: new money from the World Bank is now poured into a "Health for Africa Fund" for the promotion of private health services, at the same time that the financial crisis has shown that the neoliberal mantra: "markets are best" has made a crushing landing.

Particularly in the unregulated markets in developing countries with often fragile governments and insufficient authorities believing in the positive effects of business competition for quality and reduced costs is rather a myth from economy textbooks while the reality is rather fatal: more private medicine means mostly more costs and more risks for the patients.

A global health financing, oriented towards solidarity, must strengthen specifically public health structures, with good controls and citizen participation – avoiding authoritarian Welfare-States

In this spirit, medico international is interested to encourage debate for a "World Health Convention", Today in Geneva, in a coalition of AIDS- and other Health Activists following the Stoney Point-meeting "Bridging the Gap" in 2009, and further on during our own conference in September in Berlin just before the High Level Mid Term Review on the MDGs.

We believe that the development of such a campaign for a global solidarity needs public pressure for the realisation of these ambitious goals – as I said in the beginning, only in times of conflict and transformation it can be realized.