People's Health Movement and International People's Health University announces

IPOL Political Economy of Health

Welcome and introduction

Welcome to the first specialised IPHU On Line (IPOL) in Political Economy of Health. This IPOL involves 13 units over 26 weeks. Each unit includes readings, exercises and discussion. The full reading program and associated exercises are set out below in this Study Guide.

Purposes

The purpose of this IPOL(PEH) program is to provide opportunities for people's health activists to explore the political economy of global health in a systematic and collaborative conversation. We have scheduled the discussion across 26 weeks in order to ensure we have enough time for our readings.

Through IPOL (and other movement-building initiatives) PHM aims to strengthen the networks, organisations and movements around the world struggling to achieve 'health for all'. Read more about the PHM vision in the People's Charter for Health.

Objectives

Graduates of this course will be better able to

- interpret current local issues in relation to the global economy and global governance;
- explain how their own local economy is located in the global economy and the how the specific dynamics of this location affect people's health;
- explain how national governance is constrained by its location within the global regime;
- contribute to the development and implementation of strategies which address the local and specific issues in ways which also contribute to global governance reform and a more equitable and sustainable economy.

Study program

1. Health development: how health improves
2. The global economy
3. Neoliberalism
4. Global governance and global health governance
5. WHO
6. Trade and health
7. Foreign aid, development and health
8. Health systems strengthening (including medicines and privatisation)
9. Action around the social determinants of health (food, extractive industries)
10. Political theory and activist strategy
11. Social movement activism
12. Building the people's health movement

13. Conclusions, reflection, evaluation

The discussion will be structured around 13 two week topics (as above). Each topic will include:

- Overview (objectives, rationale, scope)
- Readings (pdfs in DropBox, websites)
- Webinars
- Exercises to be shared by email
- Skype conversation
- Postings on PEH blog

Topic	Reminders to be posted	Webinar presenter	Webinar date	Deadline for exercises to be shared	Group Skype conference to be scheduled
Topic-1: Health development: how health improves					
Topic-2: The global economy					
Topic-3: Neoliberalism					
Topic-4: Global health governance					
Topic-5: WHO					
Topic-6: Trade and health					
Topic-7: Foreign aid, development and health					
Topic 8: Health systems strengthening					
Topic 9: Action around the social determinants of health					
Topic 10: Political theory and activist strategy					
Topic 11: Social movement activism					
Topic 12: Building the people's health movement					
Topic-13: Conclusions, reflections and evaluation					

Note that the learning objectives (below) are designed to guide the facilitators more than the participants. The full implications of these learning objectives may not be immediately clear to all participants although they should become clear after the unit is completed. Participants may choose not to spend too much time on the learning objectives and just focus on the readings and the exercise; this would be fine. On the other hand time spent working out what the learning objectives refer to will not be wasted.

We will be working in small groups who will communicate with each other by email and via Skype (text and voice) and via a group specific blog. Each small group will have two facilitators. Each small group will have their own list address and their own blog.

Each topic cycle will take two weeks including the reading, submitting the written exercise, circulation of feedback and the small group on line discussion. Participants can move faster than this if they choose.

There is no right number of words for the written exercises. If you are a practised wordsmith able to pump out the paragraphs we would urge you to limit your production to perhaps 1000 words. On the other hand if you find writing slow and painful and you would prefer to limit your exercises to say 300-400 words that would be fine too.

The webinars will be broadcast on YouTube and discussion will be mediated via Skype (text only). The URL for the YouTube broadcast will be notified on the day via Skype and on the IPOL(PEH) website.

Skype

If you are not already a Skype user, please download Skype now and start exploring its functions. Your facilitator will email you shortly to arrange the first Skype teleconference for your group.

Internet problems

Please let us know (ipol_peh@phmovement.org) if you have difficulty accessing the web, email or Skype; if so we will try to make alternative arrangements.

Study Guide

Topic 1. Health development: how health improves

Learning objectives

Participants will:

- gain familiarity with the cases, research and commentary regarding the links between population health status (aggregate and distribution), specific health risks (aggregate and distribution) and the broader system of economic relations and political governance prevailing in those times and places;
- gain familiarity with the cases, research and commentary regarding the links between changes (across time) in population health status, the changing prevalence of specific health risks (of those times and places) and the changing dynamics of economic relations and changing structures of political governance across such time periods;
- gain familiarity with the cases, research and commentary regarding the role of social movements in driving historical change where the changes in health status and specific risks can be linked to changes in economic relations and political governance structures;
- gain skills in applying these methods of analysis and generalisations to the specific challenges of people's health activism in their own communities, localities, countries, regions:
    - contemporary patterns in population health status (in relation to specific health risks and the wider political economy);

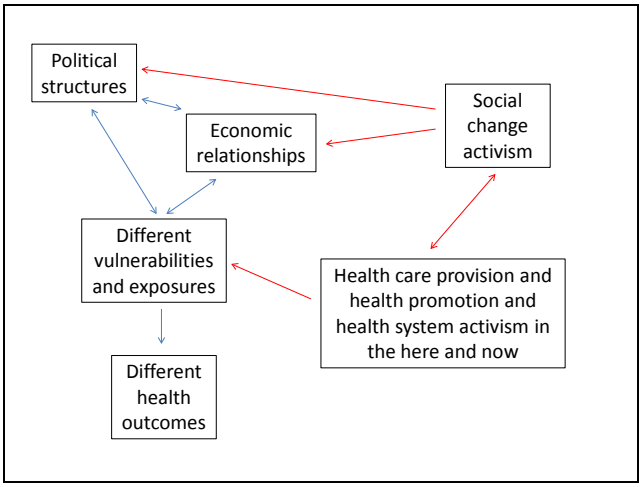
- historical changes (remote or recent) in health status in relation to changing patterns of health risk and changes in the wider political economy;
- current opportunities for people's health movement activists to confront the specific risks to population health in ways which also address the need for changes in economic relations and political structures.

Purpose and scope

Our focus in this short course is on the relationships between population health and social conditions, in particular political and economic circumstances. We can take two perspectives on this: first, the cross-sectional analysis (or synchronic) and second, the longitudinal (or diachronic) approach.

In the cross sectional analysis we can relate the distribution of health across the population (including access to health care) to the social circumstances of various subgroups within the population. This kind of analysis points to the ways in which different vulnerabilities and exposures, associated with different social locations, are reflected in different levels of health. In activist terms this analysis points towards remediation in the here and now: better protection against hazards, improved access to decent health care.

In the longitudinal analysis we seek to understand these relationships in more dynamic terms; how population health is affected over time by the changing political and economic structures which reproduce (or ameliorate) a wider range of vulnerabilities and exposures.



There are no necessary contradictions between working on vulnerabilities, exposures and health care in the here and now versus working for changes in the political structures and economic relationships which reproduce those patterns of vulnerability and exposure. Indeed, the principle of working on the immediate and local needs in ways which also contribute to structural change is integral to the primary health care model.

However, the kinds of knowledges, skills, strategies, and forms of action needed to drive change in political structures and economic relationships are not the same as those involved in delivering health care and health promotion (and developing the institutions of health care and public health).

Addressing the NCDs epidemic may involve seeking to regulate food and beverage marketing and to change price relativities so cheaper foods are healthier foods. However, a political economic perspective would highlight the global structures which give transnational

food companies so much power over the food environment and which protect them against effective regulation.

One area which has been thoroughly worked through concerns the sanitary revolution in England and the Szreter critique of McKeown is of particular interest here. In his interpretation of health improvement in 19th century England, McKeown emphasised improvements in diet and nutrition, pointing to improved living conditions associated with economic development. More recently Simon Szreter has reworked the same territory (with the benefit of some additional datasets) and has argued that McKeown underplayed public health advocacy and the incremental victories of the public health movement.

The Szreter critique of McKeown concerns the relative significance of economic development versus public health regulation and education. They are in agreement in discounting the relevance of sick care provision in the improvements in health status observed during the 19th century. (McKeown's discounting of the importance of clinical medicine in population health gain in the 19th century provoked a significant backlash against him from among clinicians.)

Clearly Szreter's critique has particular relevance for contemporary health activists because of the emphasis he plays on the social movements which drove public health regulation (in contrast to the less deliberate effects of rising standards of living). However, the specifics of 19th century England should not be mindlessly universalised.

In Australia during the 1980s and early 1990s a crude interpretation of McKeown's thesis played a significant role in a low key policy debate regarding Indigenous health. During this period Indigenous health at the federal level was funded through a generic Indigenous administration (ATSIC, the Aboriginal and Torres Strait Islander Commission) and the dominant view within that commission (informed by a reading of McKeown) was that Aboriginal health would improve when economic participation and living conditions had been addressed and on this basis the funding of Aboriginal specific health services was closely contained. Following the transfer of health funding responsibility to the Commonwealth Health Department, the funding of health services was significantly increased and within a decade evidence of an impact of health services on population health status was emerging.

A somewhat different argument regarding AIDS in Sub-Saharan Africa arose in the mid 1990s regarding treatment versus prevention; the argument being that 'treatment' would not be a cost effective approach to the epidemic and that the priority should be on 'prevention'. The Treatment Action Campaign and the broader AIDS movement rejected this position and through their activism forced the implementation of treatment programs (incidentally reducing the cost dramatically in doing so). More recently it has become clear that treatment is a form of prevention.

Causal attribution can be of great importance to particular interest groups. The decline of cardiovascular disease mortality in most industrialised countries since the 1960s and 1970s has been subject to meticulous epidemiological enquiry with the clinicians emphasising blood pressure treatment and coronary care and the public health practitioners emphasising tobacco control and dietary change.

A different set of interests can be identified in the policy debates over magic bullets such as vaccination. Dubos was an early critic of (what he called) the doctrine of specific aetiology, meaning that there is a specific cause and by implication a specific treatment. In contrast, Turshen uses the term 'non-specific mortality' to describe how children, immunised

against measles but living on an inadequate diet in insanitary conditions, are not 'lives saved' but may go on to die of other preventable causes.

The attraction of the magic bullet for the Gates Foundation is the possibility that the embarrassment of low health standards in developing countries can be addressed without challenging the political regime which shores up an unequal and unsustainable economic system globally (including the benefits which flow to the principals associated with the Foundation).

The progressive decline in tobacco use in most developed countries since the 1960s provides a useful case study for teasing out the interplay of social marketing, clinical counselling, litigation, regulation, personal choice and culture change. Social marketing and clinical counselling both contributed to culture change/behaviour change which created a constituency for litigation (especially around second hand tobacco smoke) which created further pressure for regulation. However, individual and collective choice (culture change) should not be constructed purely as the outcomes of behavioural engineering; to do so discounts the refusals of young people, the struggles of addicts and the collective processes which drive culture change.

A different debate has taken place in relation to health in developing countries around the 'good health at low cost' countries and in particular the significance of female education. Girls' and women's access to education is clearly associated with good health at low cost. However, in some accounts this is explained in fairly instrumental terms: educated women make better mothers. Caldwell has argued that the relationship might be more complex; that societies with greater gender equality, in which women can participate in decision making in the household, the market place and the forum, will be societies in which children are better cared for and in which women are able to access education.

Many of our insights into the links between health improvement and social change come from historical epidemiology, demography and social epidemiology as well as history, sociology and political science. However, academia is part of the established regime and it is well to maintain a critical stance in relation to the ideological tinting that can appear in the practice of these disciplines. Three particular features of mainstream epidemiology and public health are worth noting:

- the fetish of measurement;
- the privileging of reductionist 'evidence'; and
- the objectification of people, patients and communities.

The fetish of measurement refers to the appropriation of choice through technicist objectification. Two particular examples: disability adjusted life years and contingent evaluation. Both illustrate epidemiological/health economics methods which seek to render in single figures judgements which might alternatively be seen as properly the outcomes of social, including political, processes.

The privileging of reductionist constructions of evidence (and the discounting of contingency) can be illustrated in relation to commentary and research on health systems and the one size fits all generalisations which can be derived through the 'controlling out' of context. World Bank researchers (Preker and Harding) have studied different health systems, focusing on that which is common and excluding that which is unique, and come up with a one size fits all formula for health system development, summed up in the sequence: autonomisation to corporatisation to privatisation.

The construction of patients and communities as passive objects to whom clinicians, public health experts, government officials and politicians do things is to be contrasted with the idea of the co-production of health at both the clinical and population levels. The agency of patients, citizens and communities is quite fundamental to the social movement strategy of social change.

Readings

(Note that readings which are available in pdf form but are copyright will be made available through a password protected website on a fair dealing basis.)

WHO, *Global health risks: mortality and burden of disease attributable to selected major risks*2009, Geneva: World Health Organization. (http://www.who.int/healthinfo/global_burden_disease/global_health_risks/en/index.html)

McKeown, T., *The role of medicine*1979, Oxford: Basil Blackwell.

Szreter, S., *The population health approach in historical perspective*. American Journal of Public Health, 2003. **93**(3): p. 421-31.

Virchow, R., *Report on the typhus epidemic in Upper Silesia*. Social Medicine, 2006[1848]. **1**(1): p. 11-99.

Legge (02, in preparation). *Global health crisis.*

Legge (11, in preparation). *Learning from history*

Webinar

The webinar for this topic will feature … talking about the political economy of health; an historian's view (tbc).

Exercises

Please undertake one or more of the below tasks, preferably all of them, and post your comments on the group blog.

- Describe the health status and the distribution of health in your own country and relate it to levels and distribution of health risks and relate this to the economy (including your country's location within the global economy) and the structures of political governance.
- Describe the main changes in population health status in your country over the last 50 years and relate this to changes in health risks and the wider political economy.
- Identify one group of conditions in your country where there has been good progress over recent years or decades. What were the factors driving those improvements (from the immediate influences to the more distant influences)?
- Select one group of morbidities from the following list. Summarise the economic and political determinants influencing that group of morbidities.
    - food related morbidity: hunger, wasting, stunting, micronutrient deficiencies, NCDs, food borne disease;
    - morbidity associated with patriarchy: girl child survival, relative stunting, maternal mortality, gender based violence;
    - the morbidity associated with alienation, exclusion and powerlessness (violence, alcohol, NCDs, obesity, etc);
    - occupational exposures and vulnerabilities (injury, disease, self-esteem);

    - living environments (housing, toxics, green space, biodiversity, climate);
    - Indigenous health disadvantage.
- Why were small pox and polio amenable to magic bullets but malaria and tuberculosis less so?
- Comment on the assumptions regarding causation and strategy underpinning the WHO Global Health Risks report (reference above).
- Read McKeown and Szreter (cited above). Write a brief account of the main elements of Szreter's criticisms of McKeown.
- Read Virchow (2006[1848]), cited above. Describe the links identified by Virchow between patterns of morbidity, specific risks and the political economy of Upper Silesia?

Skype discussion

Review purpose and scope of this topic

Discuss the email exchanges and blog postings

Topic 2. The global economy

Learning objectives

To broaden the range of 'partial stories' regarding the global economy that we can draw upon in making sense of our concerns and plans as health activists;

To develop the skills involved in putting together narratives of description, explanation and prediction regarding the macroeconomic dimensions of the issues and projects which concern us as people's health activists.

Purpose, scope and focus

The dynamics of the global economy shape in various ways the health chances of people all over the world. Creating environments which can deliver 'health for all' requires knowingly and deliberately reshaping the global economy.

Stories about the global economy play a powerful role in political debate including debate over health care and policy debates which shape the social determinants of health. To participate effectively in such debates people's health activists need to be able to strip the ideological spin from conventional accounts of the global economy and advance alternative (clearer and more useful) accounts which can inspire and inform activism for health.

In this topic we take a 'partial stories' approach to understanding the global economy. When we speak of 'understanding' the global economy it is generally because we are seeking to explain particular phenomena or to plan to achieve particular objectives. In these circumstances we put together a story which is structured around those phenomena or objectives. It is a story which is centred on our interests and our agency. It is not an objective account of the global economy, like the physicists' account of the collapse of a neutron star, standing apart from our interests and our agency.

The global economy is too complicated for any comprehensive account which is sufficiently detailed to answer all of the questions that we might put to it. Furthermore, the boundaries of 'the global economy' (what we might decide to include in the stories we tell about the economy) vary according to who is asking the question and why. At its most expansive the global economy includes everybody and everything; in more restrictive constructions it might be restricted to entities engaged in monetary transactions. There are no

absolute criteria for setting such boundaries. (In more theoretical terms, the fundamental barrier to producing an objective account of the global economy is that we are inside it, we are part of it.)

The partial stories approach involves recognising the impossibility of a single comprehensive account of the global economy but instead focusing on collecting a library of partial stories which can be drawn on when we need them. They provide the building blocks for the stories we tell about the global economy, centred on our concerns, purposes and our agency, when we need them. We select from our library of partial stories those insights or generalisations that are needed for the purpose we are addressing. This is actually how mainstream economists work and certainly how business oriented economic commentators work although don't expect them to acknowledge this.

For this reason we approach 'the global economy' in this topic with a collection of some of the most important partial stories which we will need to put together the narratives about the global economy which will illuminate the causes and the strategies which we are focused on. These partial stories include:

- original myths:
    - from the stationary gift exchange economy to division of labour; primitive accumulation: from local bullies to conquest to mercantilism; capitalism: the role of capital, innovation and trade in wealth creation; the functions of money, debt, banking and the creation of money;
- neo-colonialism:
    - role of slavery, conquest, colonialism, imperialism in supporting industrialisation in Europe and North America; neo-colonialism as a way of framing the modern economy;
- the debt trap:
    - OPEC, Yom Kippur, cheap money, stagflation, monetarism, Reagan and Thatcher, impossible debt, IMF, structural adjustment and the lost decade
- global reach:
    - TNCs and 'global value chains' (global sourcing, distributed production, global marketing, intra-corporate global trade, transfer pricing); political and economic power of TNCs;
- production capacity overhang (over effective demand):
    - the long boom, the 1970s inflexion and the long stagnation; post-Fordist imbalance (stagnant demand linked to shrinking high wage employment); the growth of the finance sector (casino capitalism);
    - neoliberalism as adaptation to post-Fordist crisis;
- Chimerica:
    - low wage platforms and the shift of manufacturing; controlled exchange rates; dollar surplus; purchase of US bonds; strong dollar (based on Chinese lending) maintains US purchases of Chinese products; implications of GFC;
- post-industrialisation:
    - industrialisation, globalisation and post-industrialisation; low wage production platforms, transfer of manufacturing; the rise of the service industries (servants, hospitality, health care, finance);
- Casino capitalism:

    - production capacity overhang and the shrinking of productive investment; global finance and new forms of speculation; wealth creation versus wealth redistribution; expropriation the obverse of speculation; the rise and rise of debt powered consumption;
    - Subsectors of 'the financial sector' (and costs, sources of revenue, sources of profit etc for each, risks and risk management): deposit taking banks, investment banks, hedge funds, private equity funds, venture capital funds, pension funds, managed investment funds, wealth funds, high wealth individuals, insurance companies
    - International financial governance: IMF, Basel Committee, City of London, Paris Club; policy debates: reserve deposits, official interest rates
- tax evasion
    - transfer pricing; tax havens; money laundering
- asset bubbles and financial crises:
    - tulips, South Sea, Mexico, Argentina, Russia, Asian crisis, the dot.com tech wreck, US sub-prime mortgage crisis, European sovereign debt crisis;
- sub-prime mortgage crisis:
    - search for speculative opportunity, risk transfer (slicing, dicing and on-selling) and irresponsible lending; derivatives (mortgage backed derivatives, credit default swaps); over-lending; lending long but borrowing short; too big to fail; haircuts and bail outs; impact on economic inequality; liquidity crunch
- European sovereign debt crisis
    - German banks lending euros to Greek governments; rising debt levels; liquidity crunch with GFC; increasing cost of roll overs; ECB and German Central Bank as the local IMF: austerity as condition for bailouts;
    - original sin: Maastricht should have included fiscal as well as monetary union (?); monetary union deliberately abolished national level central banks (which can manage debt by printing money and inflating) and prevented possibility of depreciation; ultimate effect is massive transfer in wealth from Greek people to German banks
- economics of health:
    - damage to health as a negative externality (the health of workers (and environments) consumed in creating profit); good health as an input to agricultural and industrial productivity; economic development as a condition for health development;
- sustainable economic development:
    - need to distinguish between economic growth (GDP) associated with growth in material consumption from growth in non-material consumption, eg service transactions; continuing importance of innovation, technology, commerce and trade and wealth creation;
- polycentric regionalism:
    - alternative to globalisation; South South trade versus North South trade; trade within TNCs versus trade between countries;

This approach implies that first, we need to build our own personal libraries of partial stories (see Question 1. below); and second, that we need to develop the story building skills needed to explain our concerns and to inform our plans (see under Q2, below).

Readings (indicative)

- World Economic Situation and Prospects 2013 (http://www.un.org/en/development/desa/policy/wesp/index.shtml)
- GHW3 (2011) A1. Economic crisis and systemic failure: why we need to rethink the global economy,
- GHW3 (2011) C3. Trade and health
- Harvey, D., *The enigma of capital and the crises of capitalism.* 2010, Oxford, New York: Oxford University Press.
- Akyüz, Y., Financial crisis and global imbalances: a development perspective, 2012, South Centre: Geneva.
- Graeber, D., *Debt: the first 5,000 years*. 2011, Brooklyn New York: Melville House. (see)
- Legge (2013). *The global economy.*
- Rethel, L. and T.J. Sinclair, The problem with banks, 2012, London and New York: Zed Books.
- Shaxson, N., Treasure islands: tax havens and the men who stole the world, 2012, London: Vintage Boks.
- Wikipedia, Google Scholar and general browsing
- Real-World Economics (browse all issues)

Webinar

The webinar for this Topic will feature … talking about the crisis of capitalism (tbc).

Exercises

1. Explicating 'partial stories'

Work in small groups of two or three. Select three of the themes listed above and brainstorm together the elements of a 'partial story'. Think about description, explanation, prediction and prescription. Prepare a brief paper summarising your 'partial story'

Many of these topics are dealt with in Legge (2013) *The global economy* and the notes under each theme above should provide some guidance about the story but you will need to delve into reference material. There is a huge amount of material out there on the internet, including in Wikipedia and Google Scholar; more than enough to decipher the short hand notes in the above list.

2. Synthesising macro-economic stories around our concerns

Still working in your small groups brainstorm the following questions and (as a group) prepare notes in response to one (or preferably more) of the questions:

- Why does the US insist on tighter and tighter IP protection in the preferential trade agreements which it has negotiated since the WTO?
- Why are privatisation and small government such important elements of the neoliberal program?
- UN DESA (reference above) states that 'The world economy is on the brink of another major downturn'. Explain why.

- Sketch a plausible scenario through which the world moves to an equitable and ecologically sustainable global economy.

Skype discussion

Review purpose and scope of this topic.

Discuss the email exchanges and /or blog postings

Topic 3. Neoliberalism

Learning objectives

Participants will

- gain a clearer understanding of how the neoliberal storyline sustains the prevailing global economic dispensation including the inequitable flow of money and power to the benefitting elites notwithstanding the progressive destabilisation of the environment; and continuation of the global crises (health, finance, climate, etc)
- develop a critical appraisal of the neoliberal representation of the economy; be able to engage with the arguments and evidence assembled by neoliberal commentators in terms of critical appraisal of the arguments and evidence adduced and critical analysis of the interests and politics driving such representations;
- be skilled in identifying and naming the diverse expressions of neoliberalism in policy discourse and in explaining significance of the neoliberal story line, both in relation to each particular argument and in terms of shoring up globalised capitalism (despite the worsening inequities, instabilities and unsustainability).

Purpose, scope and focus

Neoliberalism is a representation of the global economy; its shape, dynamics, development and governance. It is a story which projects unending economic growth with flow on benefits which ultimately trickle down to everyone, and where the benefits generally outweigh the costs. This story is shaped and projected by, and serves the interests of, a particular set of agents and institutions.

The ascendancy of the neoliberal story has paralleled the increasingly unbalanced and unsustainable character of the global economy. Neoliberalism serves to perpetuate the privilege of the global elite, in the face of widening economic imbalances, by justifying policies which preserve privilege at the cost of austerity, exclusion, exploitation and environmental degradation.

Some of the key features of the neoliberal story line are: the very positive representation of (what are represented as) ‘market forces’; an extremely negative view of any prospect for democratic, dialogic, consensus-oriented policy making and economic management (including hostility to particular forms of regulation).

From a PHM perspective (informed by a rights, equity and sustainability perspective) the neoliberal representation serves to prop up a global economic system which is unstable, inequitable and unsustainable and which is associated with a highly inequitable distribution of costs and benefits (including in relation to the conditions for health and health care). It does so by providing ideological support for a particular configuration of global economic governance which, notwithstanding the label of ‘free markets’, is about the continued

privilege of the global bourgeoisie, the continued global hegemony of the USA and Europe, and the continued dominance of the global economy by transnational corporations, largely based in the USA and Europe.

The power of the neoliberal narrative is summed up in the Thatcherite slogan, 'there is no alternative' (TINA). TINA absolves the foot soldiers of globalised neoliberal capitalism from any sense of disquiet regarding their role in continuing impoverishment, widening inequality and environmental degradation. TINA disempowers the alienated, exploited and excluded by rendering invisible any dialogic, democratic pathways to alternative more equitable and sustainable futures; in such circumstances, retreating to fundamentalist certainties and the bliss of an afterlife makes perfect sense.

Accordingly the 'health for all movement' needs to question and counter the neoliberal story and to project alternative ways of understanding the global economy and the possibility of alternative futures; not necessarily as a stand-alone polemic but conveyed in the ways we speak, in the ways we approach health problems in our communities.

Background

Neoliberalism is a reference to an older 'liberalism' which emerged as a political slogan/ movement in 18th & 19th century England. Liberalism was primarily a political philosophy which was opposed to the absolutism of feudalism, for example, the 'divine right' of kings. It included a concern for human rights and a gradual move to democratic institutions.

However, the rise of liberalism in the 18th & 19th century England must also be understood in the context of the economic developments which were happening at the time and the needs and forces arising from them. In this respect 'liberalism' sought to free the market from privileged rent seekers (eg from various feudal and royal monopolies) and to free foreign trade from protectionism or mercantilism.

The term neoliberalism refers therefore to the struggle to free the market from government imposition; a struggle which has been transplanted, from the 18th century struggle against feudalism to a 21st century struggle *against* democratic governance; indeed against democracy itself. The core principles promoted now under the flag of neoliberalism include the 'free market' and 'small government' and a distrust of democratic decision making as compared with the invisible hand of market forces.

Critics of neoliberalism first, criticise the core assumptions and second, point to the use of this policy paradigm to advance the interests of the transnational corporations and the governments and elites whose interests are aligned with the transnational corporations.

Criticising the core assumptions involves recognising the realities of market failure (measured against the achievement of basic human rights and a more equitable, sustainable world economy). The fundamental faith of neoliberal dogma is the blind beneficence of market forces. Against this stands the Enlightenment promise of rational, collective, consensus directed social decision making through the protection of basic freedoms and democratic norms and institutions. Climate change is the challenge *par excellence* against which to compare blind market forces against the vision of democratic process.

The second element of the critique of neoliberalism is the demonstration of how, in practice, the policies favoured by neoliberalism are necessary to shore up the continuing privileges of wealth and power of the captains of industry, their servants in government in the metropolis and their partners in the periphery.

The failure of neoliberalism to address market failure while maintaining this flow of political benefit can be analysed in relation to:

- 'small government', 'steering not rowing', 'deregulation';
- the contradiction between slogans of 'deregulation' and the reality of new forms of regulation (entrenched in 'free trade' agreements), such as those regarding intellectual property rights and investment protection;
- the contradiction between the claims for the 'free market' and the demands for publicly funded bail outs for those who are 'too big to fail';
- the moral panic promoted regarding government debt (as opposed to corporate or household debt).

Readings

Harvey, D., *A brief history of neoliberalism*. 2005, Oxford: Oxford University Press.

Harvey, D., Neoliberalism as creative destruction. Annals of the American Academy of Political and Social Science, 2007. 610: p. 21.

Rowden, R., The deadly ideas of neoliberalism: how the IMF has undermined public health and the fight against AIDS2009, London and New York: Zed Books.

Friedrich Hayek and the usefulness of price setting through free markets in determining distribution within the economy as compared with bureaucratically determined pricing (web browsing, starting with Wikipedia)

Milton Friedman and the debates over Keynesian economic policy in particular in the context of late 1970s stagflation (web browsing, starting with Wikipedia)

See also the readings listed under Topic 2, above.

Webinar

The webinar for this topic will feature … on neoliberalism (tbc)

Exercises

Take one of the following issues and explore: first, the strengths and weaknesses of the neoliberal position and, second, the flow of political benefit arising from the adoption of the neoliberal policy position:

- 'steering not rowing' (eg corporatisation, privatisation, contracting out);
- the contradiction between slogans of 'deregulation' and the reality of new forms of regulation such as those regarding intellectual property rights, government procurement, investor protection, etc;
- the demands for publicly funded bail outs for those who are 'too big to fail';
- the moral panic promoted regarding government debt (as opposed to corporate or household debt).

Skype discussion

Review purpose and scope of this topic

Discuss the email exchanges and /or blog postings

Topic 4. Global governance and global health governance

Learning objectives

Participants will:

- be more familiar with the pressures and pathways through which health systems and the determination of population health are shaped by the structures and dynamics of global governance;
- have a clearer understanding of how the structures and dynamics of governance (locally, nationally, globally) can be reshaped; and how the structures and dynamics of global health governance and global governance for health can be reshaped;
- have a clearer understanding of how governance reform can be embedded in local responses the immediate health problems which communities are facing (the macro-micro principle).

Purpose and rationale

It is one thing to criticise the way the global economy works, including: how it impacts on health; how the overuse of fossil fuels is causing global warming; how the conduits and barriers of migration contribute to further inequalities; etc.

However, to change these features (economic relationships, patterns of production, management of national borders), requires new dynamics and structures of governance. The intentional control of human destiny depends on the structures and dynamics of governance; operating in a dialectical relationship with the institutions and norms of civil society and the structures and dynamics of the economy.

The work of health activists may be thought about as including several levels: from the domain of health (including the determination of health); to an understanding of the global economy; to an engagement with the structures and dynamics of governance.

Background

Governance is about how collective decisions regarding the structures, relationships and dynamics of social life are made and implemented. In an absolutist or totalitarian polity such decisions are seen as belonging to the sovereign or the ruler. Of course the concept of the sovereign ruler needs to be qualified recognising the compromises and expenditures that the sovereign deploys to maintain his power. The transformation from monarchy to representative government perpetuates the idea of a ruler, this time rule through sovereign government. However, the power of sovereign government is further constrained by the independent judiciary, the power of recall of the electorate, and the power of money and persuasion at election time. In many respects the institutions of government are just the final common pathway through which the computations of governance are implemented.

Applying these ideas to global governance underlines the limits of usefulness of the singular ruler model. There is no global government. The UN system comprises a number of intergovernmental fora with quite limited powers. The Bretton Woods institutions clearly play a role in global governance but they are not The Government. The global equivalent of national legislation includes a wide range of treaties, generally with limited sanctions. (The exceptions are the suite of investment and trade agreements which do have sanctions, most of which are at the disposal of richer countries and corporations.)

The rising interest in the discourse of governance reflects a recognition that 'collective decisions' are being taken and implemented at the global level which powerfully influence the structures, relationships and dynamics of social life but that the concept of 'government' is too limited in seeking to understand and participate in such decision making.

To be useful an expanded concept of global governance needs to accommodate:

- intergovernmental debate and agreement;
- the projection of military and financial power by large and powerful states;
- institutions which are created to mediate or modulate imperial power (the World Bank, the G20),
- the various 'communities' of transnational corporations and financial institutions exercising power through money, economic threats and ideological persuasion
- the alliances and oppositions of differently defined constituencies globally (defined in terms of class, culture, nationality, etc)
- the social movements which reflect the agency of various interest groups globally.

Burris argues for a focus on 'institutional nodes' and relationships between such nodes as a way of imagining the structures of global governance. Curran applies the framework of complex adaptive systems which imagines a universe of agents all watching each other and adapting their behaviours according to intrinsic 'rules' according to their perceptions of the movements of the wider system. Curran points out that their knowledge is always incomplete and therein lies the unpredictability of the system. The complexity framework also provides for progressive transformation of the system, understood as multiple iterations of various cycles, during which the system retains a degree of order despite changes in structure and dynamics. More worrying the complexity framework also provides for instability and quite dramatic phase changes. Camilleri and Falk take a long historical view and tell a story which accommodates evolution and culture in shaping the ways human agents relate, adapt and respond. This is a valuable contribution because it points out how the deliberate shaping of our own culture (and subjectivities) plays an important role in the deliberate shaping of our collective destiny.

In recent years the terms global health governance and global governance for health have emerged. Global health governance refers to the structures and forces which frame the collective decisions which are focused explicitly on human health and health care. Global governance for health refers to the structures and forces which shape the social determinants of health. In both cases these are merely expressions of global governance generally and it would be a mistake to see them as operating in some separate realm.

The task of the health activist is to worry about improved health care and to advocate for action on the social determinants of health. These projects involve worrying about the ways in which culture and the economy shape what is possible and worrying about how old patterns are stabilised and reproduced. Such analyses may benefit from the idea of governance.

The intentional control of human destiny depends on the structures and dynamics of governance; operating in a dialectical relationship with the institutions and norms of civil society and the structures and dynamics of the economy. The work of health activists may be thought about as including several levels: from the domain of health (including the determination of health); to an understanding of the global economy; to an engagement with

the structures and dynamics of governance as well as engaging directly the institutional and normative levels.

Readings

Camilleri, J.A. and J. Falk, *Worlds in Transition: evolving governance across a stressed planet.* 2009, Cheltenham UK and Northampton MA USA: Edward Elgar. (book)

Curran, S.R., The Global Complexity Framework. Globalizations, 2008. 5(2): p. 107-9. (DB)

Ng, N.Y. and J.P. Ruger, Global health governance at a crossroads. Global Health Governance, 2011. 3(2): p. 1-37.

Hettne, B. and B. Odén, eds. Global Governance in the 21st Century: Alternative Perspectives on World Order. Studia Latina Stockholmiensia No. 482002, Almqvist & Wiksell International: Stockholm.

Burris, S., P. Drahos, and C. Shearing, Nodal Governance. Australian Journal of Legal Philosophy, 2005. 30: p. 30-58.

Legge (05, in preparation). *Global health governance.*

Webinar

The webinar for this Topic will feature Ron Labonte (tbc)

Exercises

In what ways are the problems of health care in your country shaped by the dynamics of the global economy or the pressures of neoliberalism? Can you identify the structures and forces of global governance which reproduce these problems?

In what ways is the burden of disease in your country shaped by the dynamics of the global economy or the pressures of neoliberalism? Can you identify the structures and forces of global governance which reproduce these patterns of disease?

How might the structures and forces of global governance be reformed in order to more effectively address the needs for health system development and for action on the social determinants of health?

What kinds of strategies are open to social movements like the people's health movement to effect such reforms?

Skype discussion

Review purpose and scope of this topic

Discuss the email exchanges and /or blog postings

Topic 5. WHO

Learning objectives

Participants will

- be familiar with the history of the WHO (and antecedent bodies) and will be able to describe and explain some of the critical episodes in that history which reflect the structures and dynamics of the wider field of global health governance;

- be familiar with some of the leading issues currently (and recently and in prospect) being considered through the WHO structures;
- have a clear analysis of the costs and benefits of more intensive civil society engagement in the politics of WHO, including member state policy and performance.

Scope and focus

The WHO is the leading global health policy authority. It has persuasive authority and can adopt binding regulations. However, the limits of what WHO can do are set by what the member states agree to and agree to pay for. The history of and struggles at the WHO provide a window on the broader field of global health governance since before the international sanitary conferences in the 19th century.

WHO is presently in deep trouble (it always has been). The 'great powers' have maintained a freeze on mandatory (assessed) contributions, and the Organisation has come progressively to depend more and more on donor funding. There are sharp contradictions between the directions adopted by the member states in the governing bodies and the programs and purposes which the donors are willing to fund. One of the major weaknesses of the WHO is the lack of accountability of member states for their policies and performance at WHA and regional committees. Stronger civil society engagement in shaping member state policies in WHO and calling government representatives to account could greatly strengthen the organisation.

PHM's engagement in the field of global health governance is presently focused on the WHO Watch project. This involves monitoring and advocacy in relation to the debates and deliberations of WHO's governing bodies at the global, regional and national levels. WHO is only one of many different organisations involved in global health governance but it provides a useful lens through which the wider scene can be viewed. More about WHO Watch can be found here.

Other important intergovernmental bodies which also exercise power in global health governance include: UNICEF, the World Bank, UNAIDS and a suite of global health initiatives (GHIs) established over the last two decades. The mandates and policies of these bodies also reflect the dynamics operating across the wider field of GHG.

Readings

- The Lancet, Who runs global health? The Lancet, 2009. 373(9681): p. 2083.
- John Farley. Brock Chisholm, the WHO and the Cold War. Vancouver: Univ of BC Press. 2008. (book)
- Litsios, S., The Christian Medical Commission and the development of the World Health Organization's primary health care approach. American Journal of Public Health, 2004. **94**(11): p. 1884-1893. (DB)
- Litsios, S., *The long and difficult road to Alma-Ata: a personal reflection.* International Journal of Health Services, 2002. **32**(4): p. 709-732. (DB)
- Roemer, R., A. Taylor, and J. Lariviere, Origins of WHO Framework Convention on Tobacco Control. American Journal of Public Health, 2005. 95(6): p. 936-938.
- Laing, R., et al., 25 years of the WHO essential medicines lists: progress and challenges. Lancet, 2003. 361(9370): p. 1723-29. (DB)
- Godlee, F., WHO in retreat: is it losing its influence? British Medical Journal, 1994. 309: p. 1491-5.

- Walt, G., WHO under stress: implications for health policy. Health Policy, 1993. 24: p. 125-144. (DB)
- WHO, History of the WHO Framework Convention on Tobacco Control, 2009.
- Legge, D.G., *Future of WHO hangs in the balance.* BMJ, 2012. **345**: p. e6877. (DB)
- Legge (06, in preparation). *WHO*

Webinar

The webinar for this Topic will feature David Legge

Exercises

1. Select (share) one of the following episodes from WHO history to investigate and report upon:
   - the transition from malaria eradication to malaria control
   - the adoption and implementation of small pox eradication
   - the lead up to the Alma-Ata Declaration
   - the debates between comprehensive and selective PHC
   - the development of IMCI
   - the emergence of UNAIDS
   - WHO engagement with IMPACT
   - the IHP+
   - benefit sharing and PIP
   - WHO engagement with IP issues over the last decade
2. Describe the mandate, character and performance of the Codex Alimentarius
3. How do you think PHM's WHO Watch project should be developed in future years?

Skype discussion

Review purpose and scope of this topic

Discuss the email exchanges and /or blog postings

Topic 6. Trade and health

Learning objectives

Health activists need to

- understand how trade relations affect health, both through direct influences on particular health risks, but also indirectly through effects on the national and local economy and economic participation;
- understand the structures which govern global trade, the structures of trade agreements and the processes through which trade agreements are negotiated;
- have a range of strategies and models of practice for civil society mobilisation and advocacy around trade agreements and related issues.

Scope and focus

Trade can contribute significantly to economic development. However, trade relations can be configured in many different ways; regional or global, equal or unequal, etc. And trade relations are only part of more complex configurations of institutions and relationships.

Trade relations affect health in many different ways and formal trade agreements also affect health, partly through their impact on trade relations. However, 'trade agreements' are increasingly used to drive economic integration under conditions of unequal power and conflicting interests. Trade agreements in the service of neo-colonialism impact on health in many ways apart from facilitating trade.

Since the late 1980s trade agreements have played an increasingly significant role in structuring the global economy; first through the WTO agreements; then through a myriad of investment agreements; and later through the proliferation of bilateral and plurilateral 'free' trade agreements.

As a consequence trade agreements comprise an increasingly important element of global governance, including governance for health. Accordingly the negotiation of such agreements is a critical decision point in shaping trading relations, economic integration and global governance.

Policy coherence is an important slogan in this context, speaking about the need for trade officials and health officials to understand each others' worlds so that wherever possible win win outcomes can be achieved. Broadening the concept somewhat policy coherence also invites civil society activists to look for health and economic outcomes.

However, there are limitations to coherence. The policy logic of the neoliberal program, structured around the privilege of the global elite who are struggling against growing imbalances in the global economy (see Topic 2), requires the continuing and expanding expropriation of value from the periphery to the centre; from the masses to the elites.

Readings (indicative)

- Blouin, C., J. Heymann, and N. Drager, eds. *Trade and Health: Seeking Common Ground*. 2007, McGill-Queen's University Press: Montreal, Kingston, London, Ithaca.
- Hawkes, C., et al., Trade, health and dietary change, in Trade, food, diet and health: perspectives and policy options, C. Hawkes, et al., Editors. 2010, Blackwell: Chichester. p. 3-15.
- GHW3 (2011). *C3. Trade and health*, in *Global Health Watch 3*, People's Health Movement, et al., Editors. 2011, Zed Books: London.
- GHW2 (2008). *C3. Reflections on globalisation, trade, food and health*, in *Global Health Watch 2*, People's Health Movement, Medact, and Global Equity Guage Alliance, Editors. 2008, Zed Books: London. p. 126-139.
- PHM (2013) Trade and health: an enquiry into the role of the World Health Organisation in promoting policy coherence across the fields of trade and health and in particular, the origins, implementation and effectiveness of World Health Assembly Resolution 59.26 on International Trade and Health (DB)
- www.bilaterals.org
- Public Citizen. Eyes on Trade
- Global Development and Environment Institute, Tufts University. Globalisation and Sustainable Development Program
- Legge (07, in preparation). *Trade and health.*
- Wikipedia and Google Scholar!

Webinar

The webinar for this Topic will feature … (tbc)

Exercise

Share the following questions around the group; each person to work up their topic and then share short briefing papers and discuss in Skype workshop.

- What is the WTO? What are the WTO agreements? How does WTO work (governance, dispute settlement, etc)? What are the key WTO agreements which affect health and how?
- Name and describe five major regional / preferential trade agreements which are currently under negotiation. Discuss the implications for health arising from one of these agreements.
- Why has intellectual property come to feature so strongly in contemporary 'trade' agreements?
- What is investor protection? Discuss the concept of policy space and explain how trade agreements can impinge on policy space.
- What are some of the differences between North South trade and South South trade?
- What is the meaning of policy coherence as incorporated in WHA59.26? How can people's health organisations engage in mobilisation and advocacy around trade?
- Discuss the principles of (i) infant industry protection (as elaborated in 'dependency theory'); and (ii) free trade as elaborated in neoliberal theory. Expound the logic and explain the politics of each theory.

Skype

Review purpose and scope of this topic

Discuss the email exchanges and /or blog postings

Topic 7. Foreign aid, development and health

Learning objectives

Participants will:

- have a broad familiarity with the institutional structures, relationships, policies and practices involved in the foreign aid industry;
- have a critical analysis of the significance of various forms of foreign aid in terms of:
    - supporting, distorting or preventing social, economic and political development;
    - health care, health system development and addressing the social and environmental determinants of health;
    - changing or maintaining prevailing economic and political relationships;
- have a broad familiarity with various civil society organisations and movements involved in the delivery of foreign assistance and in the shaping of foreign aid policy;
- have a range of strategies and models of practice for civil society mobilisation and advocacy around foreign aid policy and programs, in particular, as they affect health.

Scope and focus

Where does foreign aid come from? What are the underlying drivers? What are the official 'principles'? How do the underlying drivers relate to the overt principles?

How is foreign aid collected, channelled and disbursed? What are the main institutions which intermediate foreign aid; how are they constituted, what are their interests and accountabilities, and how do these shape the impact of foreign aid?

What is 'development'? Is it the treatment or prevention of specific diseases? Is it the acquisition of economic capacity (in which case does it matter how that capacity is managed)? In what respects might 'development' be about culture? In what respects might development be about governance, social and political decision making?

Is development a linear sequence of identified stages? If not, what is it? What are the relations between foreign aid and development?

Is 'development' a process which is only relevant to resource poor countries? Does this mean that the rich countries have reached the pinnacle of social development? Why is their 'development' not on the global agenda (eg in the MDGs and the post 2015 development goals)?

How does foreign aid reflect and influence the wider global political economy; the structures, relationships and dynamics of the global economy and of global governance?

Readings

- IPHU Library: Development assistance and health
- UNDP Annual World Development Reports
- UNCTAD Annual Reports
- Rome, Paris, Accra, Busan
- OECD DAC
- GHW1 (2005). E5. Aid,
- GHW2 (2008). D1.3. The Gates Foundation
- GHW2 (2008). D1.4. The GFATM
- GHW2 (2008). D1.5. The World Bank
- GHW2 (2008). D2.1. US Foreign Assistance in Health
- GHW2 (2008). D2.2. Canadian and Australian Health Aid
- GHW2 (2008). D2.3. Security and Health
- GHW3 (2011). D2. WHO: Captive to Conflicting Interests
- GHW3 (2011). D3. Conflict of Interest within Philanthrocapitalism
- GHW3 (2011). D6. International Health Partnerships+: Glass Half Full or Half Empty
- MDGs and Post MDGs
- Sen, A., *Development as freedom*1999, Oxford: Oxford University Press.
- People's Health Movement. *Health in the post 2015 development agenda*. 2013 [sighted 2013 4 March]; Available from: http://www.phmovement.org/sites/www.phmovement.org/files/PHM%20statement%20submitted%20to%20the%20WHO.pdf.
- Organization of African Unity, A New Partnership for Africa's Development (NEPAD), 2001.

- Agu, V., A.N. Correia, and K. Behbehani, Strengthening international health co-operation in Africa through the regional economic communities. African Journal of Health Sciences, 2007. **14**: p. 104-113.
- Biesma, R.G., et al., The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS control. Health Policy and Planning, 2009. **24**(4): p. 239-252.
- Labonte, R., et al., Fatal Indifference: the G8, Africa and Global Health2004: UCT Press and IDRC.
- Labonte, R.S., Ted , D. Sanders, and W. Meeus, Fatal Indifference: the G8, Africa and Global Health2004: UCT Press and IDRC.
- Sanders, D., Global health initiatives: context, challenges and opportunities, with particular reference to Africa, Undated.
- Legge, D. and D. Sanders, Commentary: new development goals must focus on social determinants of health. BMJ, 2013. **346**.
- Legge (08, in preparation). International financial assistance for health and 'development'

Webinar

The webinar for this Topic will feature … (tbc)

Exercise

There is almost nothing about foreign aid, either for health or generally, in the declarations of Savar, Mumbai, Cuenca and Cape Town. What should they have said?

It is widely accepted that the proliferation of vertical funding programs over the last 10-15 years (eg GFATM, PEPFAR) have created new vertical barriers to integrated health systems. Discuss possible policy pathways (from where we are now) towards a global health development regime which would support the development of comprehensive integrated health systems based on the principles of primary health care.

Skype

Review purpose and scope of this topic

Discuss the email exchanges and /or blog postings

Topic 8. Health systems strengthening (including medicines and privatisation)

Learning objectives

Participants will develop their:

- familiarity with the jargons and models commonly used to describe and analyse health system issues and to develop policies and strategies;
- understandings of the common patterns and dynamics of health system development (including various national histories of health systems development but in particular the histories of health system development in their own country);
- understanding of the politics of health system policy, at the national and global levels:
- familiarity themes and debates in health systems policy in both HICs and L&MICs
- principles for activism in relation to health systems.

Scope and focus

Health systems development is shaped by the big trends and events of history and the study of health systems development starts with history. The study of different health system histories offers the following generalisations:

- the 'health system' is a lens through which we view the whole of society; health system development cannot be divorced from social development generally;
- the decisions which shape health system development always have different implications for different constituencies and are generally fiercely fought over; (health system development as a 'strife of interests');
- institutional development in health care builds on what has come before; is constrained by what has gone before;
- prevailing cultural norms play a powerful role in the shaping of health systems;
- leadership makes a difference; many different forms of leadership: health care innovators, political leaders, academic researchers and commentators, bureaucrats and community leaders;
- technological development shapes institutional development;
- expenditure growth and increasing pressures on public revenues are a common experience;
- the looming crisis of global capitalism exerts powerful influences on health systems in all countries.

The different kinds of health systems operating in different countries of the rich world maybe categorised in various ways:

- mandatory social insurance,
- publicly owned, funded and delivered,
- nationalised insurance with mixed service delivery,
- stratified subsidised insurance supported private health care.

It is important to be familiar with the prototype cases of these models and with their historical trajectories, both past and present. These patterns have been quite influential in shaping the advice of experts and donors from the rich world providing assistance to the resource poor countries.

The trajectories of health system development in the low and middle income countries and the prevailing policy models being advocated from the rich world can be discussed in terms of historical phases:

- colonial health care systems and post-colonial health care;
- the short-lived rise of comprehensive primary health care;
- selective primary health care and vertical programming;
- structural adjustment and the destruction of health systems;
- health sector reform and stratified health care;
- vertical disease specific programming;
- return to health systems strengthening or universal health cover (?).

The madly swinging policy models foisted on low and middle income countries dependent on foreign assistance need to be understood in the light of the wider political and economic issues of the time, for example:

- selective PHC and the end of the long boom (the economic inflexion of the 1970s); structural adjustment as a flow on from this;

- the legitimation crisis of IMF and the debt regime in the late 1980s early 1990s and the ascendance of the World Bank (and its stratified model of health care);
- the emergence of effective treatment of AIDS and the legitimation crisis of the IP regime of the WTO; leading to the GFATM, PEPFAR and numerous global health initiatives;
- to fragile legitimacy of the vertical disease funding model and variously, health systems strengthening or universal health cover.

While the prevailing nostrums of global health policy (reflected in the advice proffered to (or forced upon) the governments of L&MICs) have reflected the priorities and pre-occupations of the neoliberal governors of the global economic regime, there is much of substance in the orthodox research and commentary which progressive forces need to access.

However, it is also important to recognise the dominance of methodological reductionism in establishment health services research, in particular, the search for universal patterns and rules and the controlling out of that which is unique and contingent in particular national settings. Nowhere is this reductionism clearer than in the 'building blocks and control knobs' school of policy which focuses largely on the components of health systems (workforce, organisations, assets, information, etc) and the dynamics of health system functioning (the flow of patients, information and money, and governance).

There is much of value in this field of research and commentary but it needs to be approached with a clear appreciation of the constraints of neoliberal policy paradigms and methodological reductionism.

In contrast to the economic commentary on health systems political science research provides some key ideas for recovering the idea of health systems as organic wholes which are in effect co-terminus with the wider society. These ideas include: convergence, path dependence, complexity, incrementalism and windows of opportunity. Drawing on this tradition we can formulate a number of useful principles for health activism in the field of health system strengthening:

- study the histories of health systems, in particular, your own;
- critically engage with the changing discourses of global health systems policy;
- critically engage with the technical literatures of health systems science;
- engage in continuing policy analysis and policy development regarding the problems of your system with a particular focus on the problems which are faced by those most disadvantaged by the system;
- be prepared for emerging opportunities for advocacy and mobilisation; have the policy ideas ready and the networks primed;
- invest in policy capacity building;
- stoke the policy conversation through position statements, presentations, discussions and local research;
- project a vision of the health system we want which can inspire officials, politicians and civil society activists;
- build a constituency for health system reform, particularly among those who have most to gain, and among the health activists and practitioners who care about those who have most to gain.

Readings

- World Health Organization, The world health report 2000: health systems: improving performance, 2000, World Health Organisation: Geneva.

- Blendon, R.J., M. Kim, and J.M. Benson, The public versus the World Health Organisation in health system performance. Health Affairs, 2001. 20(3): p. 10-20.
- WHO, Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action, 2007, WHO: Geneva.
- McKee, M., Measuring the efficiency of health systems. BMJ, 2001. 323(7308): p. 295-296.
- Segall, M., District health systems in a neoliberal world: a review of five key policy areas. International Journal of Health Planning & Management, 2003. 18: p. S5-S26.
- De Vos, P., W. De Ceukelaire, and P. Van der Stuyft, Colombia and Cuba, contrasting models in Latin America's health sector reform. Tropical Medicine and International Health, 2006. 11(10): p. 1604-1612.
- Italian Global Health Watch, From Alma Ata to the Global Fund: The History of International Health Policy, 2008.
- WHO, Declaration on strengthening district health systems based on primary health care, 1987. p. 26-27.
- WHO, Initial summary conclusions: maximising positive synergies between health systems and global health initiatives, 2009, WHO: Geneva.
- Legge DG (2013). Health systems strengthening

Webinar

The webinar for this Topic will feature David Legge

Exercise 8. Health systems

Name a few of the major health system problems in your country. Choose one. Describe and explain the problem. What would the PHM policy position be? How would PHM push ahead with its preferred policy options?

Skype

Review purpose and scope of this topic

Discuss the email exchanges and /or blog postings

Topic 9. Action around the social determinants of health

Learning objectives

Participants will gain in familiarity with:

- the main specific determinants of health including the webs of causation behind those specific determinants and the public health principles involved in the design of programs directed to those specific determinants;
- the causal webs through which poverty, powerlessness and alienation exacerbate vulnerabilities and increase exposures to many of the more specific determinants of health;
- the economic relationships and governance structures at the national and global levels which reproduce these general and more specific determinants of health;
- strategies and forms of practice which support direct action around specific risks while addressing the wider determinants and the economic relations and governance structures;

- some famous moments from the history of public health in which effective action on the SDH (in these terms) have been taken.

Scope and focus

The recrudescence of interest in the social determinants of health in recent years is to be welcomed but it is not a new discovery. Public health activists over many years have drawn attention to social determinants of health and also to the high levels of risk associated with poverty, powerlessness and alienation. Virchow's 1848 report on the typhus epidemic in Upper Silesia describes clearly the combined operation of these factors in mediating the excess health risks carried by the local population.

What is new is the increased attention paid to these issues through the emergence of social epidemiology and the increasingly firm evidence that hierarchical subordination can mediate risks to health above and beyond the risks associated with poverty. Much of this body of research has been quite reductionist focusing on relationships between methodological variables and discounting the narratives through which we might make sense of the whole. Health activists in Latin America have responded to this reductionism with an insistence on talking about the determination of health, pointing to the agents and transactions through which health or lack of it are determined, rather than accepting disembodied 'determinants'.

The focus of the social epidemiological researchers has been very much on description and explanation. In so far as there has been increased attention given to action on the social determinants of health it has focused largely on targeted action around specific determinants: road traffic accidents, non-communicable diseases, water supply and sanitation, etc. This focus on specific determinants of health is useful but not sufficient because action structured around specific determinants fragments any consideration of poverty, powerlessness or alienation which are embedded more deeply into social, economic and political relations.

From a people's health movement perspective it is useful to think about several different frames of analysis:

- specific determinants;
- general determinants including culture (eg solidarity or inequality), economic capacity, institutional legacies, etc;
- power relations (as they affect specific and general determinants);
- economic relations and the structures and dynamics of governance.

Vulnerabilities and exposures with respect to specific determinants are shaped by economic capacity, power relations and governance. The macro micro principle suggests that we address the local and immediate issues in ways which also contribute to redressing the more macro and long term structural factors which reproduce those local and immediate issues. In relation to social determinants this means developing strategies for addressing the specific determinants in ways which also build capacity, redress inequalities in access to resources and political power, and also work towards more democratic and accountable structures of governance.

The activist perspective is different from that of the public health professional or the health promotion professional (although professionals can be activists). The activist looks also towards:

- building a social movement rather than just 'intervening';

- working on the priorities of the community/ies (rather than the narrowly defined agenda of professional programs);
- working beyond the institutionalised role boundaries of bureaucratic programs and professional socialisation;
- addressing the local and immediate in ways which also drive change in economic relations and governance structures.

Readings

- Giugliani, C., et al., The Green Area of Morro da Policia: health practitioners working with communities to tackle the social determinants of health, in Case studies on social determinants of health 2011, WHO: Rio de Janiero.
- Virchow, R., Report on the typhus epidemic in Upper Silesia. Social Medicine, 2006[1848]. 1(1): p. 11-99.
- Labonté, R. and T. Schrecker, Globalization and social determinants of health: Introduction and methodological background (part 1 of 3). Globalization and Health, 2007. **3**(5).
- Blouin, C., M. Chopra, and R. van der Hoeven, Trade and social determinants of health. Lancet, 2009. **373**(9662): p. 502-7.
- Commission on Social Determinants of Health, Closing the gap in a generation: health equity through action on the social determinants of health2008, Geneva: WHO.
- Szreter, S., *The population health approach in historical perspective*. American Journal of Public Health, 2003. **93**(3): p. 421-31.
- Legge (10, in preparation). Action on the social and environmental determinants of health

Webinar

The webinar for this Topic will feature … (tbc).

Exercise

The macro micro principle suggests that we address the local and immediate issues in ways which also contribute to redressing the more macro and long term structural factors which reproduce those local and immediate issues. In relation to social determinants this means developing strategies for addressing the specific determinants in ways which also build capacity, redress inequalities in access to resources and political power, and also work towards more democratic and accountable structures of governance.

Name a few of the most salient SDH in your country (eg the shaping of the food environment). Explore the application of the macro micro principle in relation to one or two of these.

Skype

Review purpose and scope of this topic

Discuss the email exchanges and /or blog postings

Topic 10. Political theory and activist strategy

Learning objectives

Participants will gain in their familiarity with:

- major streams of thinking (and practice) in relation to social change and political strategy; and the historical development of these traditions;
- the relevance and validity of these streams of thinking to health activism in their (participant's) settings.
- the usefulness of these different streams of thinking for talking about social change strategy in their present settings.

Scope and focus

Political activists and political scientists have discussed how humans can collectively exercise (at least in some degree) intentional control (rationally conceived and consensually adopted and implemented) over their shared destiny:

- from the divine right of kings to human rights and self-determination,
- economic liberalism and the struggle against feudalism,
- the Enlightenment, progress and representative democracy,
- the communist tradition,
- colonialism and national liberation,
- social movement theory, including the labour, women's, anti-racist movements etc;
- neoliberalism, the dangers of government, the beneficent albeit invisible hand of the market and the very intentional hand of the TNCs and their think tanks,
- governance theory,
- complexity theory, and
- relativism (and realism).

The Declaration of Alma-Ata can also be interpreted as a strategy of health improvement through social change. The Declaration emphasises the role of PHC practitioners in working with their communities to confront the barriers to their health and well being, including through large scale social change. It also endorses the calls for a New International Economic Order as a precondition for improving population health status.

PHM activists generally work within a social movement strategy but their strategic choices can be enriched by a closer familiarity with the different schools of thought about social change and political strategy. These traditions provide a language and a library of concepts through which we can bring into discourse our own sense of how best to confront the challenges we face. Bringing our experience, our body knowledge and our sense of priorities into discourse allows us to share and collectively evaluate and develop our own thinking.

Readings

http://en.wikipedia.org/wiki/Principles_of_war

Luther, Bentham, Rousseau, Jefferson

Marxists Internet Archive (nd) Democratic Centralism

Dewey, J., Democracy and education: an introduction to the philosophy of education, [1916] 1966, McMillan: New York.

http://www.freire.org/paulo-freire/concepts-used-by-paulo-freire/

Frantz Fanon

Osborne, D. and T. Gaebler, *Reinventing government*1992, Reading, MA: Addison-Wesley.

Burris, S., P. Drahos, and C. Shearing, Nodal Governance. Australian Journal of Legal Philosophy, 2005. 30: p. 30-58.

Curran, S.R., *The Global Complexity Framework.* Globalizations, 2008. **5**(2): p. 107-9.

Legge (2013) *Political theory and activist strategy*

Webinar

The webinar for this Topic will feature … (tbc).

Exercise

Compare and contrast the political party mode of activism and the social movement mode of activism. Why has the former receded in recent years as a source of inspiration for young people? Can these two kinds of political strategy be brought together? How?

Skype

Review purpose and scope of this topic

Discuss the email exchanges and /or blog postings

Topic 11. Social movement activism

Learning objectives

The purpose of this unit is to bring into focus the principles and forms of action in which activists may engage; to build the language within which we may reflect upon, and improve, our practice.

Scope and focus

An activist is someone who is ethically driven to go beyond the boundaries of their conventionally 'assigned' social role to work for social change. A social movement activist is one who orients their activist work within the broad purposes, analysis and norms of a particular social movement. A people's health movement activist is one whose actions, beyond their conventionally assigned social role, are oriented around health care and/or the social conditions which shape people's health and who works within the purposes, analyses and norms of the people's health movement.

An activist is not necessarily good. Anton Brevik is an activist. A social movement is not necessarily good. Al Qaeda is a social movement.

Our focus from here on is on the people's health movement, defined as the loose aggregation of individuals and organisations whose work is broadly aligned with the People's Charter for Health.

Social movement activism is predicated upon a set of assumptions about how social change takes place and how political activism can drive social change. In any particular case the activist draws upon an eclectic set of insights about what is happening and what might happen; 'partial stories' of description, explanation, prediction and strategy.

The narrative which integrates these partial stories into a coherent analysis and plan of action is based on local knowledge, prior experience (embodied knowledge), research, theory and logic. This narrative is created in dialogue among comrades; creating a shared story

together through the sharing of different perceptions of the situation and options; bringing together different experiences, different ways of seeing the world and different theoretical resources; in a trusting relationship.

Activist practice is based on theories of social change. Not always articulated. One of the benefits of articulating our theories of social change is that we can together evaluate and develop them and perhaps practise more effectively.

Readings

Legge (2013). *People's health activism*

Webinar

The webinar for this Topic will feature Maria Hamlin Zuniga (tbc)

Exercise

List some of the forms of activism in which you have been involved. Can you identify the skills, knowledges and subjectivities deployed in these different forms of action?

What keeps you going as an activist?

Skype

Review purpose and scope of this topic

Discuss the email exchanges and /or blog postings

Topic 12. Building the people's health movement

Learning objectives

Participants will

- gain a deeper understanding the history, structures and principles of the People's Health Movement; how PHM works including our global programs;
- gain skills in applying social movement theory to the work of PHM; elaborating upon social movement theory on the basis of experience working within PHM;
- develop an approach to evaluating our process; for reflecting on how we work and how we might work more effectively; reflecting at the same time on the criteria used in such evaluation;
- develop a range of strategies for building PHM, in particular PHM's country circles, and for developing PHM's effectiveness.

Scope and focus

In previous topics in this course we have focused on PHM engaging with the outside world; working on the social determinants of health; contributing to health system strengthening; challenging the prevailing regime of economic relations and global governance.

In this topic our focus is on building PHM itself, and beyond PHM building a strong, well informed, complexly networked social movement which can advocate and mobilise around building a healthier, more equitable and sustainable world. These goals (engaging the outside world and building our own movement) are not separate projects. Rather we engage the outside world in ways which build our movement; we build the movement through our engagement.

The critical functions of PHM, in terms of movement building, are:

- Growing our activist base: recruitment, retention, learning, inspiration;
- Building new and stronger alliances and inter-organisational understandings; working intersectorally; working with communities; working across difference;
- Attracting resources; building our resource base;
- Projecting inspiration: we can make change happen; we are part of a collectivity which is struggling in the same broad direction; we are working on the issues that matter; we know where we are going; we are mutually supportive;
- Improving our effectiveness in practice (attracts people and resources; inspires people; generates positive feedback) including: situation analysis and planning; implementation projects and campaigns; learning from practice; communicating success and effectiveness;
- Organisational development: richer communication structures; new ways of sharing the work; new ways of sharing and participating in analysis and planning; new forms of leadership;
- Cultural development: stronger sense of collectivity, self-consciousness, of solidarity, of trust;
- Learning: richer understandings, wider repertoire of strategies; new forms of inspiration (including a strong capacity for learning, communicating and applying the political economy dimensions and globalisation dimensions).

PHM sees itself as driven by the priorities and concerns of community level activists; working in a dialogical relationship with various kinds of distributed leaderships. Thus for many of these 'critical functions', the principal drivers will be at the country level although supported by regional and global units.

PHM has explored many different strategies for furthering all of these objectives. Different country circles have explored different ways of approaching these functions, corresponding to their different situations and capacities.

In this topic we will take an historical and comparative approach; reflecting on our history at global, regional and local levels and comparing our experience in different countries.

Readings

Legge (2013). *Building the People's Health Movement*

Webinar

The webinar for this Topic will feature David Sanders (tbc)

Exercise

Describe the state of PHM in your country, in relation to other progressive movements engaging with health issues and in relation to the needs for strong civil society forces.

Reflect on what has worked and what has not worked in building PHM locally. What are our main resources and barriers?

What would be a reasonable set of objectives to aim for over the next five years? Sketch a strategic plan for achieving such objectives.

Skype discussion

Review purpose and scope of this topic

Discuss the email exchanges and /or blog postings

Topic 13. Conclusions, reflections, evaluation

Learning objectives

Review, reflect, evaluate, suggest

Readings

This guide

Exercise

Evaluate the course

Skype

Discuss evaluations and suggestions

Completion

Mail out request to participants to fill in the on line evaluation questionnaire

Mailing out of certificates of completion (conditional on completing the questionnaire)

Final facilitators' evaluation meeting

Write up of evaluation

Scheduling of follow up data collection