



Health for All Now!
People's Health Movement

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The People's Health Movement (PHM) is a global network bringing together grassroots health activists, civil society organizations and academic institutions from around the world, particularly from low and middle income countries (L&MIC). We currently have a presence in around 70 countries. Guided by the People's Charter for Health (PCH), PHM works on various programmes and activities and is committed to Comprehensive Primary Health Care and addressing the Social, Environmental and Economic Determinants of Health.

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Agenda Item 13.4.

Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response

Background

The delayed start of text-based negotiations to create a new Pandemic Accord has resulted in a text lacking binding legal commitments for operationalising equity, solidarity and sustainable financing for pandemic prevention, preparedness and response (PPR). It essentially leaves the unjust status quo intact. Reforms that can place the Global South on a more equal footing in future pandemics have lost power and content. These include provisions aimed at:

- promoting technology transfer;
- institutionalising a PABS system that puts pathogen access and benefit sharing on an equal footing;
- full use of intellectual property rights flexibilities without fear of retaliation;
- sharing know-how;
- financing for health systems strengthening as an essential component of PPR;
- introduction of a financing mechanism that is sustainable and accountable to WHO MS; and
- mechanisms to safeguard against the commodification and financialisation of health systems under the guise of PPR.

WHO Member States have not been able to secure an agreement and will likely demand from the WHA to allow more time for the negotiations. However, as long as the problems seen until now persist, PHM believes it will be hard to reach a meaningful agreement any time in the future.

The main problems

1. *Lack of safeguards from vested interests and absence of CSOs in the negotiating process*

The lack of transparency that characterised the 2 year-long negotiating process is a major problem. In contrast to the Framework Convention on Tobacco Control (FCTC), which establishes safeguards against the interference from corporate vested interests, international corporations - not only “Big Pharma” but also “Big Tech” and “Data Companies” - will likely benefit from the current text. What should have been a Treaty for Equity became a highly medicalized instrument, completely oriented towards extensive data-gathering and biosurveillance (likely to benefit “Big Tech” companies) and vaccines/medical countermeasures production (likely to benefit Big Pharma).

2. *Lack of equity relating to pathogen access and benefit sharing (PABS)*

Global South countries have tried to use benefit sharing in Article 12 of the draft pandemic agreement (Pathogen Access and Benefit Sharing) as a *conditio sine qua non* for the sharing of pathogens data, genomic sequence and other relevant information. With equity-related provisions being stripped away through the use of “qualifiers” such as “on mutually agreed terms”, “should endeavour”, “encourage”, and so on, Article 12 will not deliver equity. Due to wide divergence amongst member states, decisions on Article 12 have been postponed. Further negotiations on this agenda item are preferable to adopting the current text.

3. *Lack of sustainable financing*

The most recent text provides no new financing mechanism that is sustainable and accountable to WHO Member States. Nor does it include mechanisms to safeguard against the commodification and financialisation of health systems under the guise of PPR. Additionally, there is no acknowledgment that debt repayment obligations severely constrain Global South countries' capacities to build effective and equitable health systems, PPR systems, and during pandemics, social assistance to already vulnerable populations.

4. *One Health and Pandemic Preparedness*

The text pays extensive attention to bio-surveillance. Despite committing to adopting a One Health Framework, the most recent drafts have reduced pandemic preparedness to a mere exercise in bio-surveillance and data gathering. While important, bio-surveillance is a reductive approach to pandemic prevention and preparedness. As the current pandemic of antimicrobial resistance (AMR) teaches us, real prevention - in the true spirit of One Health - has to go through a radical change in the relationship that we have with animals and the surrounding environment, reducing pesticides in the agroindustry sector and eliminating the practice of unnecessarily administering antibiotics to livestock. Only engaging with bio-surveillance is a convenient but limited and short-term solution that will not address the roots of zoonotic pandemics in the long run.

5. *Lack of Civil Society Participation*

Private and personal interests should not override public health goals. Civil society organisations committed to protecting this principle have not been able to participate in the negotiations in a robust manner. This has eroded trust in the process amongst those who seek to support and advance the INB's mandate to develop an instrument informed by the principle of solidarity with all people and countries, and that frames practical actions to deal with causes and consequences of pandemics and other health emergencies. Unfortunately, the lack of CSO participation has also animated groups seeking to undermine WHO's authority to direct and coordinate the world's response to health emergencies. These groups have misrepresented the INB process as an attempt to usurp MS sovereignty or impose the use of harmful surveillance and health technologies, thereby compromising public support for this important process.

Call to Action

In light of the above, PHM urges Member States to continue the negotiations process so as to:

1. Introduce binding equity provisions in the treaty operationalising technology transfer and sharing of know-how;
2. Design a financing mechanism that is sustainable, accountable to Member States, guards against the financialisation and commodification of PPR, and does not trap Global South countries further into debt;
3. Address pandemic prevention and preparedness in a way that goes beyond mere bio-surveillance;
4. Remove vested interests from the negotiations and, as in the Framework Convention on Tobacco Control, add safeguards against them; and
5. Meaningfully engage civil society in the negotiations to ensure a process that is truly transparent, democratic and in the interest of the global public good.

Agenda Item 15.4

Climate Change, Pollution and Health

Background

The ecological crisis is the greatest health crisis of our time¹. As stated by the Lancet, it affects every aspect of our health and exacerbates pre-existing inequalities². While the Global North contributed to 92% of the historic excess carbon emissions³, and still majorly contributes to greenhouse gas emissions, populations, particularly in the Global South, get sick or die from poor air quality. Additionally, they are affected by floods, wildfires, and famines exacerbated by a changing climate⁴. In 2021 Pakistan suffered floods that displaced 33 million people, and small island states know they will be swallowed by sea level rise within a few decades. These regions contribute little to man-made climate change, but they are bearing the heaviest burden.

An underlying driver of the climate crisis includes capitalism's need for endless economic growth, which demands continuous exploitation of people and the planet. The agro-industry pushes biodiversity loss with its monoculturalism. It forms the greatest drive for deforestation. Both the fossil fuel industry as well as the agro-industry are major contributors to global greenhouse gas emissions. Extractivist practices to gain natural resources such as fossil fuels, lithium, arable land and seeds, exploit local communities and rob them of their land, pollute the air, water and soil and push the planetary boundaries until a point of no return.

An integrated, transdisciplinary approach is needed to address the converging crises of biodiversity loss, pollution, climate change, and health inequity.

PHM's Position

Placing health, justice and community at the heart of the climate response offers an opportunity to address existing inequalities in our socio-economic system. Therefore PHM underlines the need to revisit our capitalist and imperialist world order and move to post-growth economies. This would disincentivize needless overproduction and exploitation of people and the planet. Instead of profit-driven economies, we could build our communities around health and wellbeing, granting access to the commons that are crucial to achieve health: clean water and air, healthy food, education, and health care.

Call to action

PHM welcomes the adoption of the report and the climate resolution. It notes however that the resolution is insufficient to protect people's health and calls WHO and Member States to

1. Acknowledge and address the commercial drivers of the climate crisis, the need for endless economic growth demands, and the continuous exploitation of people and planets;

¹ <https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health#:~:text=Research%20shows%20that%203.6%20billion,diarrhoea%20and%20heat%20stress%20alone>

² [https://www.thelancet.com/article/S0140-6736\(21\)01787-6/fulltext](https://www.thelancet.com/article/S0140-6736(21)01787-6/fulltext)

³ [https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196\(20\)30196-0/fulltext](https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(20)30196-0/fulltext)

⁴ <https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health#:~:text=Research%20shows%20that%203.6%20billion,diarrhoea%20and%20heat%20stress%20alone>

2. Ban new fossil fuel exploration and extraction in all their forms including green extractivism; work towards a treaty to phase out fossil fuels that recognizes common but differentiated responsibilities (CBDR) and ensures a just transition, globally enforce mechanism to stop overfishing and sea-bed mining;
3. Implement public policies that radically transform our food systems to achieve food sovereignty;
4. Acknowledge the historic and disproportionate responsibility of high income countries in contributing to the climate crisis, and for high income countries to urgently reduce their emissions and environmental pollutions, act upon common but differentiated responsibilities and pay climate reparations to protect health for all; and
5. Integrate community based climate solutions, build well-being economies and place universal health care and comprehensive primary care at the heart of climate resilient health systems.

Agenda Item 15.5.

Economics and Health for All

Background

The WHO Council on the Economics of Health for All has recommended reforms aimed at strengthening public sector capacity for health for all. One way to do this is by investing in Public Pharma. Pharmaceutical production currently relies heavily on the private sector, particularly large transnational corporations known as Big Pharma which is an essentially flawed model that significantly hinders the global realisation of the right to health. The dysfunctions include: a disconnection between R&D efforts and public health needs, shortages of essential health technologies, high prices, the huge carbon footprints of pharma companies, and power asymmetries between states and transnational corporations (especially in the Global South). The COVID-19 pandemic has exacerbated these issues, but it is important to recognise that they are long standing problems that have impaired public health for decades.

What is *Public Pharma*?

Public Pharma refers to a state-owned infrastructure dedicated to researching, developing, manufacturing, and distributing pharmaceutical products or other health technologies. It encompasses all institutional arrangements in which the state has genuine decision-making power and can establish governance driven by public health needs. It does not include, for example, Public-Private Partnerships (PPPs) or any other arrangement where the state uses public resources to de-risk private enterprises.

What is missing from the current debate? A focus on Public Pharma

We welcome ongoing attempts to create legally binding obligations to promote technology transfer, full use of TRIPS flexibilities, pathogen access and benefit sharing (PABS) and pharmaceutical manufacturing in the global south. While the aforementioned objectives may expand R&D and pharmaceutical capabilities in the global south, they only amend an essentially flawed system. A state-owned and controlled infrastructure can effectively grant governments' decision-making power about health products pricing, R&D priorities and their alignment with public health needs, private entities' use of products financed by public resources, or implementation of intellectual property rights. However, state-owned and controlled infrastructure that enables researching, developing and manufacturing products aligned with public health priorities may overcome these constraints.

Call to Action

1. We call on member states to acknowledge the unsustainability of the current system of pharmaceutical production, especially highlighted by the Covid-19 pandemic, and the need to move towards a public-centered model of R&D and production of health technologies;
2. We urge Member States to instruct WHO to develop an evidence base detailing historical and contemporary case studies and best-practices on Public Pharma initiatives, so as to support and advance Member States' efforts to invest in Public Pharma in line with the work presented by the WHO Council on the Economics of Health for All; and
3. We call on Member States to initiate a programme of collaboration aimed at disseminating national experiences with Public Pharma implementation, with the goal of supporting and establishing new state-owned infrastructures for researching,

developing, manufacturing, and distributing pharmaceutical products or other health technologies in each WHO region within the next decade.

Further reading

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