Delhi Statement

Time to Untie the Knots:
the WHO Reform and the Need for Democratizing Global Health

As representatives of organisations working on campaigns for health and social justice, of academia, governments and multilateral institutions, we gathered in New Delhi from 2nd to 4th May 2011, from all parts of the world, to address the need for an effective and accountable global governance for health. In the wake of the Regional Dialogue on the right to health held in Johannesburg at the end of March, the purpose of this global consultation was to achieve a common vision for realizing the human right of everyone "to the highest attainable standard of physical and mental health ", and reignite a health for all movement with shared objectives and actions.

Health is an essential condition for human and social development. That is why the right to health is enshrined in the Constitution of the World Health Organization, in the International Covenant on Economic, Social and Cultural Rights (CESRC) and in over 130 national constitutions worldwide. Yet, it concerns us that while health is increasingly recognized in both international and national law to be enforceable, the health of the majority of world population remains insufficiently protected and promoted. In the last two decades 20 million people, at least one third of all deaths, have continued to die every year due to global health inequity.

Even now, when global health and poverty reduction are relatively high on the international policy agenda, and governments are launching directs assaults on poverty through various programmes, health inequalities within and between countries are on the rise. Persistent poverty and growing inequalities, these intractable foes, are stark reminders that economic globalization and market liberalization have not created an environment conducive to sustainable and equitable social development. On the contrary, new emerging threats to health – the global economic and financial crisis, climate change, food insecurity, mounting unemployment – can rapidly worsen an already desperate situation for billions of people, the growing poor and marginalised.

Health is a common good that demands collective responsibility. Instead, structural violations of the right to health are produced by the dominant market dynamics and the uncontrolled influence of profit-driven transnational corporations, supported by the policies of international financial and trade institutions – the International Monetary Fund, the World Bank and the World Trade Organization. Such violations are often unmonitored, unmeasured, and are too numerous to quantify. As they form part of a process of systematic violations of other rights - to gender equality, to water and food, to work and income, to housing and education - any commitment for the right to health cannot be conceived in isolation from a broader approach of universal social protection as a key policy to human development.

As the UN health agency, the WHO remains in today's globalised world the "directing and coordinating authority" for the realization of the right to health and universal coverage. Its role as the sole global legal authority in health is embedded in its constitution, and needs to be strongly supported. The last few decades, however, have witnessed the rapid emergence of new actors who have highlighted health as a priority and largely shaped the global agenda, but also contributed to much fragmentation in health governance. Their increasing prominence has produced a shift in institutional culture, favouring the penetration of market values into areas where they do not traditionally belong and resulting in a new sphere of influence in health policies. This trend has progressively stifled the voices of Member States and weakened the institutional mandate of WHO, with controversial implications.

The topics of global health governance and the WHO reform agenda were prominently featured during the WHO Executive Board debate in January 2011, a development we welcome. Fire has been lit and WHO, through its Member States, needs to take responsibility for the policy dialogue opportunity it has opened up. It is a collective responsibility, too.

Our gathering in New Delhi, just before the 64th World Health Assembly, bears witness to how seriously the process initiated by the WHO Director General is taken by organizations engaged in social justice worldwide. We are convinced that WHO needs to rediscover its fundamental multilateral identity. Drawing on its strengths, the organization has to take advantage of its reform process to rethink and reassert itself as *the* leading actor in a broader governance for health that is coherent with the need for solid public policy responses to the neoliberal prescriptions, so that globalization be shaped around the core values of equality and social justice.

But governance for health starts at home. Governments, the main stakeholders of WHO, have clear obligations to the people they represent. Beyond mere institutional approaches, issues related to public policies in health have to be democratically debated and tackled at the local, national and regional level. This entails the continued participation and meaningful contribution of communities, public opinions, and their direct empowerment through education and knowledge sharing. Unless and until governments have the people directly affected around the decision-making tables, their health policies will remain ineffective. Health democracy, namely participation, transparency and accountability in health, is a pre-condition for countries to make an impact in the decision making processes at the global level, within WHO and in other multilateral fora.

We, the participants in the New Delhi consultation

1. Call on Member States to strengthen the enforceability of the right to health, and the other economic, social and cultural rights. We draw their attention to the need for an improved legal framework to enhance the limited national enforcement provisions and absence of enforcement internationally, despite the binding nature of the right to health. Precise mandatory arrangements and monitoring mechanisms are required. We support the exploration of and research into a binding framework convention on global health, and on universal social protection to this end;

2. Are convinced that the primary responsibility to enforce the right to health lies with national governments. Any endeavour to fulfil countries' legal obligation to respect, promote and fulfil this right on a non-discriminatory and equitable manner must include communities as well as the engagement of public interest organisations. Without people's mobilization, human rights cannot be met. The right to health is no exception.

3. Consider that the implementation of the right to health, beyond its technical and legal aspects and financial implications, entails political will and policy coherence across sectors. Therefore, the right to health must have priority in all national and international negotiations and agreements that have an impact on health (environment, energy, labour, trade, agriculture, taxation). Transnational corporations are to be held accountable in this regard;

4. Urge governments to tackle the structural downsides associated with the current global health governance - its fragmentation, inadequate global leadership, institutional weakening of mandated bodies, inadequate health financing, erosion of poor countries' ownership of their health and development agenda, etc. - and overcome the poor accountability of the ever-growing number of agencies and initiatives, which has led to unnecessary high transactions costs, wasted resources, and drained absorptive capacity;

5. Favourably consider the proposal by WHO for innovative consultation mechanisms that allow meaningful participation of the multiple actors involved in global health and require that the WHO consult with public interest groups to this end. We encourage WHO to undertake and properly resource public hearings that must be inclusive, participatory, democratic, accountable and transparent, including through electronic means, in order to inform the development of relevant public health policies, rather than creating new permanent peer structures that do not

appear to tackle the heart of the global governance intricacies. A sustainable long term plans is needed to re-build a democratic and effective global governance for health;

6. Strongly challenge the increasingly disproportionate participation of the corporate private sector in WHO processes without a robust mechanism to address conflict of interests. WHO needs to develop a comprehensive framework that would guide interaction with commercial actors as well as develop and implement measures to avoid and properly manage conflict of interest situations. These go beyond transparency and include a clear definition of institutional conflict of interest, clear entry criteria and sunset clauses;

7. Demand that WHO clearly defines its stakeholders. Since the reform of the WHO is aiming at enlarging interaction, and increasing trust, with a wider range of actors, it is crucial that the reform package be characterised by a process in which the space for contributions is based on the voice and needs of people, not the power of money. This requires clear definition of actors and their roles, goals and interests. Prior to the convening of any structured public dialogue for global health, all these issues need to be addressed and clarified. This process would contribute to but not replace the formal decision making process at the World Health Assembly, where countries are represented;

8. Urge Member States to focus on taxation as one of the key policy instruments to enhance revenue capacity to advance human welfare, and in particular to finance a home-grown health agenda. Achieving the right to health and other basic rights is conditional on the availability of financial resources to fund them. We propose a human right perspective on tax systems and urge governments to intensify the redistribution of wealth for promoting social cohesion and fair growth. The world is awash in money and time has come to focus on wealth as a way to reconnect redistribution and social policy with economic and fiscal policymaking. Progressive taxation is a key process to nurture a healthy relationship between a state and its citizens, at the national and international level, beyond short-term donor support and excessive dependence on philanthropic funding. Operational suggestions in this area should be addressed and enacted through a global framework focussed on the principle of solidarity.

9. Recall that international solidarity is essential in many countries with insufficient financial potential to ensure the necessary human and material resources to guarantee the right to health. Today's non binding provisions need to be turned into mandatory arrangements if we are to make such support predictable and long term.

10. Strongly encourage Member States to increase their financial contributions to WHO and enhance their impact in the organisation. The idea that WHO should overcome its budgetary pressures by drawing resources from the private and commercial sector, as suggested in para 76 of the DG report (WHA 64/4 Future of Financing of WHO, http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_4-en.pdf), is one to be rejected.

11. Recognize that, as public interest organizations, we have to make efforts to strengthen our own transparency and enhance accountability in our work, to improve democracy on health. We commit to this goal through participatory mechanisms.

12. Engage to continuing the process of collective learning and alliance building to ensure that the right to health is placed at the centre of national and global policymaking, and to shape an effective and accountable global governance for health.

Signed by:

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