



Human Right to Health Global Campaign

Concept Note (1st DRAFT)

I. Introduction

In the wake of the global economic crisis, public healthcare has suffered attacks under the hammer of austerity measures around the world. Health and social care services at large are estimated at 5.8trillion US\$ per year, one of the largest economic sectors that has continuously grown in the past decade. Big business has pushed the liberalisation of health services, facilitating a growing role for multinational corporations (MNCs). Access to healthcare is a human right and thus a responsibility of governments and society. Private companies, by their nature, prioritize making profit and not contributing to the common good. After decades of privatization of public services, it is time for governments to take on their responsibility and to organize public services according to needs of the people. Health care is the most essential of all and thus needs to be a priority for all governments.

The changing world of work, staff cuts and attacks on health workers' trade union rights have resulted in critical shortages of provision of health services, in particular for those who cannot afford to pay for these services themselves. PSI and its affiliates have vigorously challenged this situation, raising their voices against these developments and mobilising at international, regional and local level, with the aim of putting people over profit and fighting to win universal public health coverage.

We now need to bring these efforts together into a global campaign for the human right to health, in line with the resolutions of the 29th World Congress. This concept note is an initial discussion paper towards launching the Human Right to Health Global Campaign by 13 December 2016, during the Health and Social Care Services Task Force meeting of 12-13 December in Geneva.

II. Contextual Background

"The enjoyment of the highest attainable standard of health," has been declared a human right, since 1946, with the establishment of the World Health Organization. This principle is reflected in the constitutions of many countries. Significant improvements were made after this declaration, particularly in industrialised countries. But, despite several inter-governmental covenants on universal health coverage, we remain very far from ensuring the human right to health for all.

More than 1 billion people live in poverty and have no access to drinking water, while 2.6 billion have no access to sanitation. Wars, internal conflicts and climate change continue to claim tens of thousands of lives, leaving millions more in utter misery. Health workers pay with their lives for being at the forefront of the fight against natural, man-made, and epidemiological disasters, often working without adequate protection or remuneration as the Ebola, Zika and MERS outbreaks have recently demonstrated.

We have seen enormous efforts of privatisation, liberalisation and cuts in the funding of social services, driven by free trade agreements and conditions for "aid" and loan facilities from international financial institutions. All of them are backed with promises that "markets" can do better than states because they are supposed to be more efficient and less bureaucratic. The policy space for maintaining the modest level or improving health services were constrained in the developing world due to the structural adjustment programmes of the 1980s-1990s. However, it is now recognised that these measures have led to increasing inequalities and have worsened the quality of health services. Persisting with this policy will overturn the significant improvements in health conditions and life expectancy registered in the past decades, particularly for the majority of the population in developing countries.

Due to the underfunding of public health services, hundreds of millions of poor people have to pay out of their pocket for health services. According to the WHO: "about 100 million people globally are pushed below the poverty line as a result

of health care expenditure every year”¹. In short: a lack of basic provision of health care contributes to higher inequality and extreme poverty in society.

This is a clear pointer to the critical need for universal *public* health coverage, for health as a human right to be realisable. However, what we have seen is quite the contrary. Over the past few decades, the health and social care sector has been one of the main targets in significant restructuring, with increasing *for-profit* private interests’ involvement in the provision of health services, with explicit support of governments formulated as health reforms.

Such support often takes different forms of privatisation, including Public-Private Partnerships (PPPs) as well as policies that foster transnational corporations’ expansion into health services delivery and pharmaceutical production. These health reforms are part of three-dimensional fiscal reforms: involving tighter systemic fiscal controls, new priorities for the allocation of governments’ resources spurred by a limited sense of growth, and improvement in the use of resources, from the standpoint of a lean state (Schick, 1998²).

But, the assumption held on to tenaciously by policy makers that private provision of healthcare is more efficient is not evidence-based. On the contrary: “comparisons of total health spending at national level show that countries with higher private spending on health spend more on health care and achieve worse results in key indicators of national health” (Lethbridge, 2014³).

Furthermore, due to so-called tax reforms, such as lowering the threshold and introducing flat rate taxes, big private corporations do not need to pay their fair share to contribute to public services but continue to stash away trillions of dollars which could be used to pay for universal public health and social protection coverage (Philips et al, 2016⁴).

The impact has been quite “negative and damaging” to the health and social sector (Maucher, 2013⁵). Budgetary cuts and introduction/increase in user fees have had “devastating effects” on services delivery in both developed and developing countries. Salary cuts are becoming generalised and job security, which used to be the norm in the sector, is fast becoming a mirage. The health sector has witnessed an expansion of precarious jobs and informal labour relations in addition to staff cuts and non-replacement of retired staff. This has placed heavy workloads on the health workforce, particularly amongst young workers and has resulted in worsening quality of healthcare. Overstretched health workers and increasingly frustrated patients have heightened the level of workplace violence. Women have been the most adversely affected.

The demographic unbalance between the Global North and South, lack of planning of health needs and health workforce training together with poor wages, are the main ingredients fuelling the migration of health workers from developing to developed countries. Often migrants do not know their rights and due to the lack of regular migration channels they become victims of trafficking and end up in bonded labour, despite the WHO code on ethical recruitment. The migration of health and social workers is contributing severely to the worsening of already fragile health systems and undermining the capacity of countries to respond to health crises as evidenced in the high fatality of cases during the Ebola outbreak in West Africa.

The current dramatic situation is the result of political choices and can be reversed by political choices. There are windows of opportunities for turning the tide, such as the “renewed global commitment to health, underpinned by target 3.8 for Universal Health Coverage (UHC)”⁶ and the recommendations of the UN High Level Commission of Health Employment and Economic Growth. PSI’s robust interventions⁷ contributed to this outcome. However, we have to put this commitment into practice and organise a mass global campaign for the human right to health.

This would draw on the commendable efforts of PSI and its affiliates in the sector across the different regions, and the forging of alliances -and where need be, coalitions-, with other global union federations, national trade union centres, civil society organisations, associations of patients/users of healthcare facilities and research bodies, to bring about change that would help enthrone universal access to public health as a human right.

¹ <http://www.who.int/mediacentre/factsheets/fs323/en/>

² Schick, A., 2009, “Budgeting for Fiscal Space”, *OECD Journal on Budgeting*, Vol 9/2, OECD Publishing, Paris

³ http://www.world-psi.org/sites/default/files/documents/research/2014_-_financing_health_care_-_psiru_paper.pdf

⁴ <http://ctj.org/pdf/offshoreshellgames2016.pdf>

⁵ http://www.world-psi.org/sites/default/files/documents/research/article-impact-crisis_austerity-measures-health-systems_workforce_patients-04-12-13.pdf

⁶ http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/About_IHP/_mgt_arrangements_docs/UHC_Alliance/UHC_2030_Alliance_Concept_Note.pdf

⁷ <http://www.world-psi.org/en/working-health-and-growth-investing-health-workforce>

III. Conceptual Framework

Our concept of a *human right to health* (HR2H) is based on several international instruments and documents⁸ ratified by states and governments across the world. Beyond the universal normative contents of the right to health, the extent of *formal* incorporation of these into the constitutions and legislation of individual countries, and the actual state of implementation of these would as well be of concern for the campaign, as a point of departure for our advocacy. Governments' obligations and actions taken or not towards ensuring health for all would be scrutinised, as well as the contradictions of a global world, where you can build walls to stop the circulation of people, but not viruses.

Since the '70s, there is a general acceptance, at least formally, of health as a human right in contemporary society, but we need to understand the different types of attacks that are preventing its effective implementation, such as privatisation, commercialisation, PPPs and the prioritisation of other for-profit interests in healthcare delivery. The problem is not merely the presence of private providers, but the commodification of health, driven by the financial system and MNCs that are imposing a business-based model to a sector that has the highest social relevance. Moreover, the merging of big financial and pharmaceutical corporates are creating a monopoly of a few big players in the sector which leads to the opposite of the "competition" myth. Understanding this frame and raising awareness on the consequences, will help us to highlight the positive examples that we can present as alternatives to support our campaign.

"The right to health occupies a prominent place among the internationally recognised human rights, although its formulation and further elaboration are relatively recent"⁹. This is not surprising as it bears on our very existence as well as living life in dignity¹⁰. Health is explicitly defined in the preamble of the WHO Constitution, as 'a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity'¹¹. It further emphasises that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'.

The explicit definition of health as *a fundamental human right* was made in the 1978 Alma Ata declaration. The declaration further stressed that 'the attainment of the highest possible level of health is a most important world-wide goal whose realisation requires the action of many other social and economic sectors in addition to the health sector'¹². Before this however, and subsequent to the enactment of the WHO constitution, several international covenants on human rights prioritised the right to health. The Universal Declaration of Human Rights presents the right to health as an essential component of the right to an adequate standard of living for all human beings. In Article 25 (1) it states that: 'Everyone has a right to a standard of living adequate for the health of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood, beyond his control'¹³.

This set the tone for underpinning the right to health within the corpus of the UN human rights treaty system and regional treaty systems across the world, of which the International Covenant on Economic, Social and Cultural Rights of 1966 occupies a central place¹⁴. The interconnectedness of these health-related rights, other social determinants of health and health outcomes cannot be overemphasized. While in the light of this, a progressive realisation of the right to health is realised, state parties are deemed to bear general and specific legal obligations to *respect, protect and fulfil* the human right to health. Thus, governments of state parties are supposed to: "refrain from interfering directly or indirectly with the enjoyment of the right to health"; "take measures that prevent third parties from interfering with article 12 guarantees", and to; "adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right to health".

At the heart of the Article 12 guarantees are:

- *Availability*: central to this is "functioning **public** health and healthcare facilities, goods and services, as well as programmes", which include "the underlying determinants of health, such as safe and potable

⁸ A working list of select instruments and documents in this regard can be found as an annexure in: World Health Organization. "The Right to Health Fact Sheet No. 31." Geneva: WHO. pp: 41-45. http://www.who.int/hhr/activities/Right_to_Health_factsheet31.pdf (2008).

⁹ Martins S.P., (2013), "Introduction: the Emergence and Scope of the Human Right to Health", In J.M. Zuniga, S.P. Marks, L.O. Gostin (Eds.) *Advancing the Human Right to Health*, Oxford University Press, New York

¹⁰ <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>

¹¹ WHO, 1946

¹² WHO 1978

¹³ UN General Assembly, 1948

¹⁴ There is a general consensus that the 2000 General Comment 14 of the Committee on Economic, Social and Cultural Rights (which was created to monitor the ICESCR) captures the normative essence of the human right to health. It lists 14 human rights as "integral components of the right to health". These include: "the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement".

drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, **trained medical and professional personnel receiving domestically competitive salaries**, and essential drugs” in “sufficient quantity” within each State party (emphasis by PSI);

- *Accessibility*: universal access to health facilities, goods and services, with accessibility having four overlapping dimensions i.e. non-discrimination, physical accessibility, economic accessibility (i.e. affordability), information accessibility. This serves as the conceptual pillar of **Universal Health Coverage**;
- *Acceptability*: health facilities, goods and services must be “respectful of medical ethics and culturally appropriate”. This entails respect of the culture of individuals, peoples, and communities, including minorities, as well as sensitivity to gender and life cycle requirements, and must be designed to respect the confidentiality of persons concerned, and improve their health status;
- *Quality*: health facilities, goods and services must be culturally acceptable, be scientifically and medically appropriate and of good quality. “Skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation” are some of the basic requirements for ensuring necessary **quality** healthcare, without which the right to health is compromised.

Realising the human right to health equally requires respect for *procedural principles* which as a rule apply to human rights in general¹⁵. These include:

- *Non-discrimination*: accessing healthcare and the provision of health services must be without any form of discrimination in intent or effect, based on health status, income, race, ethnicity, language, religion, sex, sexuality, disability, nationality, or social status;
- *Transparency*: health information must be in accessible language and disseminated to everyone, to enable persons and populations to have the awareness necessary to protect their health. Financing, organising and delivery of health services must be transparently carried out by institutions and personnel responsible for these;
- *Participation*: active participation of individuals and communities in decision-making on issues that affect their health, must be vigorously promoted. This must include the organisation and implementation of health services;
- *Accountability*: public agencies and private entities involved in the formulation and implementation of health policies and delivery of health services must be held accountable, including through enforceable standards, regulations, and independent compliance monitoring.

The right to health is defined and upheld in regional human rights treaties, most of which were entered into from the 1960s to the 1980s, and which are still legally in force. And “the right to health or the right to health care is recognised in at least 115 constitutions,” while not less than six other countries’ constitutions clearly stipulate duties of the state in relation to health, such as that of developing health services or allocating specific budgets to health¹⁶. These provide possible niches for campaigning for the realisation of the right, beyond the limited successes recorded thus far, in some cases, by governments¹⁷.

The Human Rights Commissions established in the different regions to monitor compliance have successfully prosecuted states’ denial of the right to health to their citizens. For example, immediate relief was won for 27 persons living with HIV in El Salvador who required triple therapy in 2001 after the intervention of the Inter-American Commission on Human Rights. These legal victories are commendable and strengthen a basis for action in case law. It is however important to note that generalisation of such benefits requires *political* action, i.e. mobilisation of popular awareness, lobbying, evidence-based research with strong research-to-action linkages. This is one of the tasks of the Human Right to Health (HR2H) Campaign. States that recognise the right to health also provide space for action, in terms of insistence on the actuality of this. Successful legal cases have been reported in Argentina, Colombia, Brazil, South Africa, Ecuador, Costa Rica and Venezuela, just to mention a few examples. Learning from these experiences will help us to understand how to work with allies, target groups and CSOs and build the strategic alliances we need to be successful.

¹⁵ <http://www.nesri.org/programs/what-is-the-human-right-to-health-and-health-care>

¹⁶ <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>

¹⁷ Article 11 of the European Social Charter of 1961 (as revised in 1996) affirms the obligation of states to take necessary measures “to remove as far as possible, the causes of ill-health” and “to ensure that any person who is without adequate resources... be granted adequate assistance, and, in case of sickness, the care necessitated by his condition”. Article 16 of the African Charter on Human and Peoples’ Rights stipulates “the right to enjoy the best attainable state of physical and mental health”. It also states that States party to the Charter “shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick”. Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 equally avers that: “Everyone shall have the right to health understood to mean the enjoyment of the highest level of physical, mental and social well-being”. The 2004 Arab Charter on Human Rights declares in paragraph 1, that: “the State Parties recognise the right of every member of society to the enjoyment of the highest attainable standard of physical and mental health, and the right of the citizen to free basic healthcare services and to have right to medial facilities without discrimination of any kind”.

IV. Towards fulfilling the right to health: contradictory dynamics

Although universally and *formally* recognised, the human right to health is under attack. Gains of the past are being rolled back, by *for-profit* interests of private providers and pharmaceutical corporations, private health insurance companies, and facility management firms. Out-sourcing and contracting out of staff and services are contributing to a decline in quality and waning affordability of health services on the one hand, and unsafe, ineffective staffing levels, lowering wages and job losses for health workers, on the other. In such a framework, it is hard to see how the implementation of the Sustainable Development Goals (SDGs) can reduce poverty and ensure universal health coverage.

Privatisation and commercialisation of health care: Evidence has shown the failures of privatizing health services. UN-DESA's paper, "Public-Private Partnerships and the 2030 Agenda for Sustainable Development: Fit for purpose?", indicates that "PPPs are less likely to deliver efficiency gains in the social sector such as hospitals and schools where access and equity are major concerns".

"Why Public-Private-Partnerships Don't Work" by Public Services International Research Unit (PSIRU) assesses the PPP experiences in countries both rich and poor. It concludes that PPPs are an expensive and inefficient way of financing infrastructure and services, since they conceal public borrowing, while providing long-term state guarantees for profits to private companies. Implementing PPPs poses important capacity constraints to the public sector, particularly in developing countries. PPPs suffer from low transparency and limited public scrutiny, which undermines democratic accountability. PPPs lead to ever-growing indebtedness of government and inflexible service agreements add on up to 20% each time they need to be renegotiated in case the needs of the population change. In addition, the indebtedness of the government can in turn have a negative impact on the provision of other public services due to dwindling resources, as well as on public health as such.

PSI proposes to avoid the promotion of PPPs for the provision of health care, while attempts at establishing standards for PPPs in health should be inclusive of all governments (including local authorities) and the major stakeholders (users of health services, health sector workers, and others). PSI also proposes that criteria be established for the evaluation and periodical review of existing PPPs in health.

PSI advocates for an overhaul of the corporate tax system, which currently sees corporations avoid over \$3 trillion in tax per year. This could help to provide the much-needed revenue to extend public services in line with the UN's Sustainable Development Goals. What we need is a clear commitment and investment in public goods and democratically transparent provision of these services that guarantee universal access and quality. For now, PPPs in the areas of health, education and water have not managed to achieve these standards – essential to the implementation of the SDGs. With regard to tax justice, we want to ensure that increased financial resources from existing and new sources, as a result of tax reform policies, are utilized to raise wages and improve employment conditions of healthcare workers, starting with the current pool of the global health workforce.

While we recognise that the private sector is present, we mostly need stronger governance, best practices and models to be rolled out globally, as well as a mapping of global players and engaging them in a process of global reform. The results of a survey of PSI health and social services affiliates showed that many health and social care services, including core and support services, are now outsourced. International companies have won at least a quarter of contracts in health services and if national subsidiary companies are included, the influence of international companies on public health and social care systems is increasing rapidly. There have been changes in the mix of different forms of health care financing, with some countries recording higher rates of out-of-pocket payments and a decline in the contribution of public health care expenditure to overall health care expenditure.

Multinational health care companies: Big businesses are using a variety of strategies to enter markets around the world. Surprising are companies moving from Africa/ Australia/Asia to Europe. Reforms promoted by the World Bank, IFC and Regional Development Banks, including marketisation, decentralisation and corporatisation of the public sector, provide opportunities for multinational companies to enter the public health care sector. The increased commercialisation of public health and social care services makes them subject to inclusion in trade treaties which will open up these services to competition from global services companies. The decisive point from PSI's experience is that the provider of health (and social) services cannot take out money from the system and share it with shareholders - who might in addition be located in a fiscal paradise. Possible gains have to stay in the system and need to be reinvested into health care systems which also means that they need to be used for good working conditions/job quality for the health workforce.

Impact of international trade on health: Trade objectives in the health sector should be compatible with other legitimate social objectives like universal access. The regulation of the health sector is necessary to protect patients, including against malpractice and the use of their personal data. Any facilitation of patient mobility should consist of three pillars – financing (reimbursement), provision of service (quality and standards) and finally after-treatment responsibilities. In economic terms, the impact on home country health systems are as follows: since people who seek their treatment offshore can take their funding with them, money is drawn out of the national health system, whose low level of investment is

often the rationale for offshore treatment, thus making the problem self-perpetuating. At the same time, it provides a justification for lower investment in the healthcare system, and training and recruitment of the healthcare workforce, while taxpayer funding for healthcare allocated to individual patients is transferred to another country's private health system. The home economy loses the dynamic benefits of health care expenditure, which accrue instead to the provider economy.

Health exporting countries will find that qualified staff are diverted to health export services that often have better pay and facilities, eroding the personnel base for public facilities and perpetuating inequalities in the health care system; education and training funded by the home country is used to benefit foreign health care users, rather than local citizens and taxpayers. Any 'necessary care after treatment' is the responsibility of the local facility, or more likely the public healthcare system, but it could see host countries and their taxpayers bearing the costs of funding remedial treatment when complications occur that require specialist facilities. Where those facilities do not exist in the country, they may have to pay the costs for remedial treatment elsewhere.

Decent work and working conditions: Universal health coverage is impossible without health workers. And to deliver quality health services, health workers need decent working conditions, and occupational health and safety. Of importance as well is freedom of association and the right to collective bargaining for health workers. Migration of professionals who leave the public system due to low wages and poor working conditions threatens guaranteed health delivery around the globe, including in paediatric services.

Cuts in public funding make these systems more fragile and work more precarious, whereas investing in healthcare delivers growth and quality of life. Home carers, those delivering elderly care, health care assistants, nurses, junior and other doctors, cleaners are all standing up for better pay and recognition of skills, qualifications and their labour rights.

Decent work has many parameters; a living wage, the right to belong to a trade union and participate in the actions of the union, the right to a safe workplace, access to ongoing education and support, sufficient down time and safe length of shifts, and opportunities for professional development and advancement are just a few of these. Decent work also requires that health care workers are able to speak freely and without fear of repercussion about the healthcare system in which they work. Indeed, when they speak about their working environment, they are primarily advocating for the rights of patients to effective, safe and quality care, irrespective of government policies.

The example of Liberia is telling in this regard, where trade union repression and intimidation is rife, and although Liberia has ratified ILO convention C98 on the Right to Organise, it still does not allow public servants to join a union. Many deaths of health workers and of the population could have been avoided if the government had listened to the unions on the situation of Ebola getting out of hand and the collapse of the public health system, as early as 2014. Current calls for the further privatization of the health system in Liberia can only lead to further global catastrophe. In many developing countries, including in South Asia, the private health sector is inadequately regulated, leading to ad-hoc remunerations, working conditions, employment contracts and benefits, and creating barriers to unionising due to the fear of losing one's job.

As a result, one or all the following characteristics are evident: a) workers are not directly employed by the primary employer – the hospital they work in or for, and consequently there is no clear employer-employee relationship; b) work agreements are often informal; and c) employment is temporary. While this is also true for workers employed to provide healthcare services directly (medical workers), this trend is even starker for workers who provide health services indirectly (non-medical workers). We need strategies to address not only formalising informal work, but also interventions to contain the informalisation of formal work in the health sector.

Investment in primary health care, preventative health care, is crucial if we want to decrease health costs – currently too much is spent on acute care, which might also be linked to the interests of the health industry; i.e. big pharma and the manufacturers of medical equipment. Primary health care and preventative health care are best carried out by community-based health care workers. However, we do stress that this is where there is a lot of underpayment, under-training and exploitation, and lack of sustainable funding.

If we want better health outcomes we need to ensure that policies, regulations and laws for adapted ratios of patients to healthcare workers, or patient quotas, are included in plans and programmes to increase employment in the health sector, and are included as issues for harmonisation at the international level, along with health worker education, qualifications and credentials. This will have an immediate impact on the working conditions and lives of millions of migrant workers in the health sector and combat the thriving social dumping.

Investment in health: Investments in the health sector—e.g. in epidemic surveillance and response—strengthen a country's ability to protect its people from infectious disease and other dangers (such as Ebola and Zika virus epidemics, but also epidemics of non-communicable disease). The effects of these epidemics can have massive costs for nations. Investments in the health workforce must make guaranteed individual and global health security a priority concern—for peace, development and economic growth.

The reality for many countries is that they are struggling with these issues in the face of ongoing conflicts, post-conflict reconstruction, or predicaments of current or recent natural disasters (such as floods, famines, and earthquakes). Around a billion people today live in fragile settings, and more people are displaced now than at any time since World War II. Maternal and child health—almost two-thirds of maternal deaths and over half of under-5 deaths take place in settings of humanitarian crisis. And many countries in partnership arrangements with development cooperation agencies are affected by conditions of fragility. These countries often lack the capacity for providing basic health and social care to their citizens. They are seeing health workers and health facilities become new targets in conflict.

Humanitarian crisis has also spilled over the destination countries of refugees. The lack of access to health care services for undocumented migrants and refugees has widespread effects. For one, limited or lack of access to health care services is highly detrimental to both mental and physical health. In turn, when migrants' health deteriorates and they are prevented from accessing necessary health services, it can have negative impacts on public health, including on the public health system.

There are also further social costs, in terms of the impacts on families and communities, of having members in poor health. Restrictive health policies can have negative impacts on health professionals, whose commitments to medical ethics are contradicted by requirements to deny care to patients due to their residence status. In response, many health professionals and other service providers strive to ensure basic health services to all, often working in difficult conditions.

V. Purpose and objectives of the Campaign

The overarching aim of the campaign would be to build a mass global movement that could influence concrete policies towards attaining Universal Public Health Coverage (UPHC).

The main objectives of the HR2H would be to:

- (a) Strengthen the efforts of PSI affiliates in the sector at national and regional levels to campaign for improved funding for health and budget accountability, towards establishing universal public health coverage;
- (b) Integrate advancing trade union rights, fighting privatisation and cross-cutting issues (e.g. migration, and climate change) into the narrative and fight for UPHC;
- (c) Stressing the role of the State to ensure human rights including the access to health;
- (d) Integrate awareness of government funded public services as being favourable to market solutions;
- (e) Deepen intervention within the mechanisms, processes and structures of global governance, which could help foster accelerated action towards implementing SDG target 3.8 and the Action Plan on the report of the UN High Level Commission on Health Employment and Economic Growth;
- (f) Work with other Global Union Federations, non-affiliated unions, national trade union centres, civil society organisations and other allies.

VI. Activities

The campaign would involve activities of PSI work at the global, regional, sub-regional, national and local levels. There would be activities directly connected with the campaign and others related to it, as part of the PSI's health sector work or to support affiliates' and allies' fights which can be related with the objective of the campaign. We need to spell out what quality public health governance is all about – to challenge governments and how they ensure human right to health, while raising the bar for private health actors around the globe and ensuring decent working conditions for health workers and quality health care for all.

- Launch of the campaign on 13 December, at the HSTF and accompanied by a media launch;
- Develop joint media and communication actions with PSI affiliates and partners in the first quarter of 2017;
- An activity at the global level *every quarter*, such as participation in health policy global events; launch of publications; public events; international guest lectures/symposiums/seminars; meeting and demonstrations; Ongoing PSI projects in the health sector will be integrated;
- Strategizing/report back on the campaign to PSI constitutional bodies (SUBRAC, RECs);
- Selecting priority themes for regional/sub-regional activities and developing training material for dedicated workshops;
- Posters/leaflets/flyers;
- A newsletter on *The Human Right to Health*;
- Engaging with the WHO/ILO/OECD on all relevant health policy issues, lobbying and providing evidence;
- Expanding the membership of (sub-) regional health networks and expanding the scope of their work;
- Forging/strengthening alliances with NGOs and CSOs that have similar aims in terms of exchanges of information, experiences & for joint actions.
- Drawing from the early experiences of the campaign for the presentation of a relevant resolution to the 30th World Congress.

VII. Expected Outcomes

The following are expected outcomes of the campaign:

- *International:*
 - ⇒ Strengthening PSI health affiliates and the improvement in the employment and working conditions of health workers;
 - ⇒ Building commitment to the pursuit of the SDG target 3.8;
 - ⇒ Supporting the tax justice campaign to fund public health systems;
 - ⇒ Enhanced visibility of PSI in the global discourse on health issues and the formulation/implementation of covenants and policies on health;
 - ⇒ Implementation of the ComHEEG report's Action Plan to support public health;
 - ⇒ Deepened cooperation with ILO, WHO and OECD on health policy issues;

- *Regional and National:*
 - ⇒ Mobilising affiliates to campaign for universal public health coverage;
 - ⇒ Enhanced visibility of PSI and its affiliates within different regions in the formulation and implementation of policies bearing on health and social services;
 - ⇒ Mobilise for legislation and policies that enhance universal access to public healthcare and strengthen national health systems;
 - ⇒ Contributing to the quantitative and qualitative expansion of the health workforce, including increases in the employment of young health workers;
 - ⇒ Promote the full implementation of Conventions and laws on Occupational Health and Safety for health workers;
 - ⇒ Develop proposals for laws, policies and regulations that take up the challenges of women health workers (such as provision of crèches in health facilities);
 - ⇒ Push for immediate reduction in the rates of violence in the workplace;
 - ⇒ Ensure greater visibility for PSI and its affiliates in national discourse and formulation/implementation of policies, on health;
 - ⇒ Increase the membership of affiliates and number of affiliates in the health sector.