Proposal Booklet

HEALTH AND ITS CHALLENGES IN THE 21ST CENTURY

"Health" Network of the Alliance for a Responsible, Plural and United World

November 2001

Warning

The "Health" network was launched at the end of the year 2000 in the framework of the collegial path of the Alliance for a Responsible, Plural and United World : the project was to gather health and social professionals at international level in order to make reflections and proposals on the issues of health in the 21st century.

Obviously, a year only is not enough to structure a really global and intercultural network. That it could be able to run a collective work of elaborating proposals too was the greatest of challenges. The "health" network nevertheless succeded in developing both at spanish-speaking countries level _ a work co-ordinated by Juan Vielmas (Chile) that resulted in organising an international meeting in Cuba in October 2001 - and at the level of french-speaking countries- a work co-ordinated by Didier Seyler, Frenchman working in the Ivory Coast.

The results of this work are thus presented under the form of two different contributions, one drafted originally in spanish, the other in french. The synthesis of these contributions and their enrichment through the confrontation with other regions of the world will be one of the tasks of the "Health" network within the next months.

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Introduction

The current crisis facing humanity is particularly manifested by the fact that a large part of its members suffer from poverty, inequity, discrimination, inequality of opportunities, technological gaps and difficult access to health, as revealed by the following statistics:

- 1,300,000,000 people live in absolute poverty – they represent 25% of the world population and earn less than one dollar per month.
- 30% do not have access to potable water.
- 1,000,000,000 suffer from anaemia due to a lack of iron.
- 200,000,000 suffer from malnutrition.
- 2,000,000 children die every year from diseases for which there is a vaccine available.
- 7,500,000 children die during the perinatal stage because of a lack of appropriate care.
- The female populations of underdeveloped countries, who represent 84% of the world's female population, have a one out of 48 chance of dying during childbirth. In rich countries, this rate is one out of 4,000 pregnancies.

These brutal statistics force us to look at the causes of this reality – all the more so given that all of the countries of the world have signed declarations obliging them to resolve these serious problems. Health is a subject that concerns all societies, and that is truly fundamental for human development; this is why its analysis is essential, and can provide us with elements to help us overcome this crisis in a more general manner.

For this reason, certain representatives of the Alliance have manifested the need to fully take on this problem and debate experiences, ideas, and above all, concrete proposals. However, we are aware that health is an extremely complex subject whose analysis is infinite. Thus, a group of health professionals (Alliance members) has made some important reflections on some of these elements, including:

- The definition of health, which should result in the establishment of a framework that would allow us to develop concrete actions and proposals in this field;
- The predominant health model or system, which has clearly shown itself to be insufficient and requiring reformulation; and
- The funding that will allow us to offset inequalities in the health field.

DEFINITION OF HEALTH

There are various definitions of health, each of which has attempted to establish a general concept applicable to each historical period. In 1948, the World Health Organisation defined health as a state of overall physical, mental and social well-being. If we used to this definition, no one would be considered healthy, since it is a utopian and extremely academic definition that is impossible to put into practice.

There are other definitions, such as that of Milton Terris, who brings to light the fact that health is not an absolute, but rather a continuous process that can range from death (which in this case would be considered the maximum state of illness) to the state of perfect health. Ilich considers that a healthy state is the ability to confront illness.

The questions we ask are: can we envisage a single definition of health that would be more operational and closer to people, or should we define general elements that will be applied to one field or another?

To what extent must we take cultural considerations into account? For example, within a definition of health, is it acceptable for some cultures to remove an adolescent's clitoris for traditional reasons?

The group of health professionals in the Alliance who have reflected on these issues at the Forum and at the Havana meetings, have stated that it is difficult to establish, by consensus, a definition that is valid for all periods and all societies. At the same time, a definition must also:

- Contain general, basic (meaning, generic) elements.
- Be locally applicable and adaptable.
- Respect cultural values as long as they do not go against human rights.

A definition must also include the following concepts:

- The right to health is a fundamental human right and an essential part of human development. As such, it is indispensable for the development of each individual.
- The healthy state is partly subjective, as it defines the idea of feeling good at different degrees, both at the present time and from a future perspective; and it is partly objective, as it reflects the functional capability allowing the individual to confront the challenges of his or her environment. This functional capability is changeable and depends on genetics as well as ageing. The two components – subjective and objective – are interdependent, and expectations play an important role.
- Health is the product of the interaction between different economic, social, political, biological, environmental, cultural and health care factors. A society will have more or less favourable results as regards the improvement of quality of life depending on the action it takes on these factors. Not long ago, Wilkinson (1992) demonstrated that the health of a population is closely linked to its different income levels, so that when a country's riches are concentrated in only a few hands, we witness a drop in the health status of the various social strata. In the words of Francis Bacon, "money is like muck, best when it is spread out".
- Health has a dynamic character that mixes the two dimensions, individual and collective. These two elements are interdependent. Certain factors come directly from states and others are individual – meaning, they correspond to individuals and their decisions. Also, the expectations of a society's models and lifestyles have an influence on individual expectations and decisions regarding health. At the same time, health transcends the individual and occurs or materialises in the family, professional and cultural environments, taking into account the fact that there are healthy societies and ill societies.

- Health improves the potential of individuals, and allows them to contemplate the future and face the challenges that arise, adapting themselves to the requirements of each situation, in order to attain a certain harmony with themselves and with their environment.
- In health, the bio-psycho-social and environmental fields come into play. To meet this objective, we must act in the sectors of promotion, prevention, re-education and rehabilitation. This requires respect for other fundamental human rights, including the right to food, shelter, peace, and civil security.
- Results regarding health are strongly determined by the levels of development of other sectors in society; these levels are surpassed if the results improve. Efforts to improve these levels are mainly focused on health care systems, probably due to the belief that health care is the determining factor in health. Although they are decisive at the individual level, the presence or absence of health services cannot explain the differences in the health status of this or that population group.

Many studies have shown that prosperity and health are closely linked. This has been observed among income groups in a single society, as well as among different societies. The growth of prosperity is an indicator of success as regards the way in which the environment has been apprehended in the past, and how it shapes the challenges of the future.

Caldwell (1986) demonstrates that within this strong correlation and interaction between health and wealth, certain societies take health-related measures that surpass what is allowed by their income level. We should also note that there are concrete social characteristics, such as mothers' high level of education.

Other studies conducted in various countries over the years have demonstrated the correlation between life expectancy and various characteristics pertaining to the social status: income, education, profession, and place of residence (Wilkinson, 1992).

CRISIS IN THE SYSTEM OF EXPERTS AND THE BIOMEDICAL MODEL

- In the Western world, health is highly medicalised and is characterised by the most extreme specialisation, which leads to the loss of a general view of human beings. This model is rooted in scientific thought influenced by Cartesianism and positivism, and results in a fragmentation of knowledge.
- This explains another important trait of this model, which is its tendency toward the indistinct use of technology within health practices, to a much greater extent than the use of human and relational components.
- Health systems have been structured on the supply of health services as defined by experts and as founded on scientific and biomedical progress, but have not been based on the real requests of the population and psycho-social conditions, which is reflected in numerous cases where health policies lack legitimacy.
- The model has been mainly focused on healing processes, to the detriment of prevention and health promotion, and in the hospital field, to the detriment to general medicine, closer to people.
- Its biomedical character has stifled the expression of other, more traditional health systems.
- The model has not been able to adapt to the current context. It has been useful for solving health problems during certain periods, but it is incapable of addressing current demographic and epidemic upheavals.
- The model shows:
    - Failures in organisation
    - A failure in human resources training
    - Limitations in the participation of individuals
    - An increase in costs
    - Dissatisfaction of the population.

- The lack of participation impedes the formation of a counterweight to this model, which results in poor support form the population and which goes against the system's representativeness and governance.

NEW HEALTH MODEL

In order to offset the failure of the above-described biomedical model, we need a new model for more humane, patient-oriented health relations, based on the following values:

- Respect for human dignity
- Respect for diversity (cultural, ethnic, sexual, etc.)
- Solidarity
- Responsibility (of all players in the system)
- Exercise of citizenship (rights and duties)
- Equity (overcoming inequalities)
- Participation.

This model must be structured in such a way that available resources will be primarily managed in a way that strives for new efficiency and equity, in order to solve the problems of the population. The approach must be social, with strong educational, participatory, multi-sectoral components; it must also integrate the following characteristics:

- Universality
- Integrity
- Continuity
- Accessibility: geographic, economic, cultural and social
- Aptitude for finding solutions; effectiveness; efficiency
- Valuing of different health practices

- Ability to adapt to cultural diversity
- Promotional and preventive
- Priority to General Medicine as a very important player, with respect to resources as a process regulator as well as a point of entry
- Public, centralised funding and control
- Allotment of public, private or mixed funds and loans
- Decentralised management
- Participation must be guaranteed for integration into decision-making levels
- The allotment of funds and loans must consider the individual as a whole, as opposed to excessive specialisation
- The model must integrate all of the technical means and socially acknowledged experiences in order to prevent and heal illnesses, giving patients a certain margin of freedom allowing them to choose what is most appropriate for them, unless it would endanger their life or physical integrity
- The model must establish the necessary conditions to allow patients to make free, conscious choices about any procedure involving them
- In decision-making, the common good must be a priority over the protective interests of corporations, which should adapt to the interests of patients.

SYSTEM PLAYERS

In order to move away from the current model, toward another model that integrates the above-mentioned characteristics, all players must assume their roles and act together; this will allow them to progress along this path. The main players are:

- Government
- Users
- Funders
- Service Providers.

There are other players who are involved in and influence the model through the main players:

- The pharmaceutical and research industry
- The political class
- The universities
- International organisations
- The media
- NGOs
- Corporations
- Miscellaneous.

The government must regulate a whole series of health activities and standards, in order to guarantee the system's participatory character.

It must guarantee the participation of service providers, and respect their dignity and working conditions.

In order for the participation of users and workers to be effective, it must take place at the decision-making level related to the planning, execution and evaluation of health policies.

This could be done through corporative management of services or establishments according to the structure of the health system under consideration, but always paying special attention to collective management processes, integrating professionals and users.

Obviously, resource allocation must consider the opinion of these levels of participation.

We must avoid conflict between players, seeking alliances that avoid corporatist attitudes (which are more at the service of their private interests than the interests of the common good, and which are cut off from the essence of the values of the model).

The government's general actions, programmes and policies must incorporate considerations in favour of the health of the population. Policies on housing, the environment, culture, education, etc. must promote health.

Users must fulfil their role as central players in the process, by demanding their participation in its definition and evaluation as that of the quality of the services provided, both locally and at the level of political power, pressuring representatives for the values of and characteristics of the new model to be respected.

Users should establish alliances with primary and secondary players in order to safeguard their interests.

Users must also assume their responsibility of taking care of themselves and adopting a healthy lifestyle.

FUNDING AND THE INTERNATIONAL SOLIDARITY FUND

Health funding must first respond to the values advocated by the health model, particularly equity and solidarity. The funds can come from multiple sources: direct taxes, general taxes, individuals, employers, etc. The best solution is a single fund.

Control of the use of funds must necessarily be centralised, in order to guarantee equity and solidarity. An International Health Fund (IHF) must be established, to contribute to improving the health status of the most underprivileged populations. The resources that nourish the funds may come from different sources and their main objective would be to initiate health development in the world's most disadvantaged regions.

This fund must be devoted to covering the health needs of the population that cannot be met by the countries due to their underdevelopment or insufficient resources.

The IHF must be governed by strict standards so that it may intervene in the countries in a way that does not distort the objective for which it was created.

It is also necessary to establish a high degree of manageability in the use of this fund, and thus the inequities and needs of these countries will be the determining factors.

In order to distribute the IHF, it is essential to create a methodological guide on which all of the members of the fund would come to a consensus.

The fund must focus its resources mainly on establishing health structures and human resources that are the countries' own, thus permitting the durability of the future system. It must also be oriented to the satisfaction of the basic needs of the populations such as sewer systems, potable water, etc., and favour certain elements, including promotion, prevention and reinforcement of general medicine. All of this must be within the complete development of a participatory health system.

Moreover, a new way of collecting and distributing the resources of this fund must be promoted, replacing the concept of charity with that of solidarity. *(Charity: a religious virtue that seeks love for one's fellow human being; alms that are given to the needy. Solidarity: circumstantial support for the cause or endeavour of others.)*

The funds should come from developed countries; they should also come from the pharmaceutical industry as a way of compensating for the injustices caused by their high profit margins on the sale of medicines. The money could also possibly come from funds that are currently being used to support various humanitarian assistance organisations.

The fund must seek the alliance of various organisations, international agencies and interested countries, in order to take the first step toward its creation.

These alliances may be simultaneously used to define the rules of organisation that can be useful for the better use of the funds currently being distributed, avoiding their misappropriation, which is a common occurrence.

Using this platform, the following stage would consist of increasing size and credibility so that the denouncement of unsuitable use of assistance will become more effective, and in order to call on the conscience of rich countries to contribute to the fund on ethical grounds.

We still need to discuss who will direct the fund and how. It seems desirable to avoid a situation where those who contribute the most to the fund are those who steer the decisions, where each part becomes the spokesperson for its own interests, where centralisation becomes excessive, or where administrative costs are too high.

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ALLIANCE FOR A RESPONSIBLE, PLURAL AND UNITED WORLD

Proposal Booklet for Tomorrow's Health
(contribution)

Memo on the Issue

12 November 2001

NOTICE

This contribution is the fruit of collective work that began in early 2001.

It has been drafted and synthesised by Didier Seyler, a French generalist physician residing in the Ivory Coast.

Numerous contributions have been made, in the following forms:

- Exchanges, discussions and re-readings of the text at multiple meetings (Abidjan and Paris) with French physicians, physicians from West African countries, and French political activists (non-physicians) contacted personally, working in West Africa and in France;

- Critical re-readings and suggestions with FPH collaborators in Paris, and with "allies", both at meetings and through electronic mail;

- Critical re-readings and suggestions after the presentation by the Alliance on specialised public health and health policy distribution lists in developing countries (especially medications); this is mainly "E-MED", which is distributed to 390 members, mostly in French-speaking Africa (46 countries) and "SANTÉ PUBLIQUE", which is distributed to some 150 French-speaking members, mostly European.

ALLIANCE FOR A RESPONSIBLE, PLURAL AND UNITED WORLD

Proposal Booklet for Tomorrow's Health (contribution)

Memo on the Issue

12 November 2001

Human health is a cross-cutting issue, one which is rarely addressed as such in all of its dimensions. Conversely, the management of most of the determinants of a good state of health (food, environment, equipment, employment, etc.) lies within the scope of political and economic logic, in which public health is never the purpose.

This cross-cutting nature leads to numerous overlaps with other issues addressed by the Alliance. Rather than a redundancy, we should see it as an enrichment, which places the point of view of human health among the priorities of the future.

In analysing the situation of the year 2000, it is interesting to develop three lines of reflection, as they cover new elements that are liable to change the approach to health in the immediate future.

- An environmental line with the emergence of the concept of the second "public health revolution";
- A scientific line, mainly centring on medications and their evolution;
- A food-related line which, for many reasons, will cut across the issue of medication and the issue of the environment.

Added to these three lines is the development of an argument on the concept of "essential information" on health matters, and on access to this information. In fact, this proposal particularly cuts across all health issues.

These are, of course, "arbitrary" choices that must not diminish other, more classic, aspects of the subject:

- Ethics, anthropology and philosophy, above all related to notions of health, death, the relationship of individuals and groups, etc.;
- The funding of health policies and actions and their links between the different geographical levels;
- The social and professional organisation of the health system;
- The place of non-conventional medications, either "modern" ones such as homeopathy, or ones that come from societies termed "rudimentary".

Moreover, the most important improvements in length and quality of life are the direct result of the general elevation of the cultural and economic status of the individuals who make up a population, rather than the actions of physicians or antibiotics, for example.

Health and the Environment

For two decades, we have observed a massive progression of serious chronic pathologies in industrialised countries: cancers, neuro-degenerative diseases, immuno-allergic illnesses (asthma), etc. In France, data from cancer records reveal that between 1975 and 1995, cases of cancer have increased by 1% every year. This progression varies depending on the nature of the tumours; for example, it is 4% every year for brain tumours.

The study of the epidemiology of cancers shows that migrant populations adopt the same kinds of cancers as those of their host country within one to two generations. People who have emigrated from Japan to Hawaii have 4 times the breast cancer rate as those living in Japan, and 4 times the rate of stomach cancer! Only the change of environment (generally including food and lifestyle) can explain such an extreme change.

This progression cannot (can no longer) be associated with the increase in life expectancy (French data have been corrected on age), or with individual behaviour, notably tobacco and alcohol use, which are decreasing, even though their proven effects are still considerable.

In industrialised countries, this is a radical, massive change that some call "***epidemiological transition***", the principal cause of non-adaptation of care systems based almost exclusively on relief of infectious and traumatic morbidity. Henceforth, medicine deals not with one or several separate morbid episodes, but with one or several processes of exposure/induction/brittleness which, by their nature and wide range, take place throughout life.

The hypothesis of a causal responsibility for psycho-chemical elements that are present in the environment and which are the result of industrial activities, is progressing. For example, pesticides are being more and more incriminated in the genesis of cancers in children. It is also suspected that asthmatic illnesses and male reproduction problems observed in the Western world may have environmental causes.

Recent findings have shown that toxic substances do not all act with a "threshold effect". This is the case of cancerogens, because of which we consider that risks exist starting at the moment of contact with a single molecule. What is important for human health is exposure to a dangerous product: this exposure can exist in all environments and at different levels. The addition of these exposures constitutes a risk that can be calculated.

The problem is that very few products (there are around 100,000) have been evaluated with these modern risk evaluation methodologies. For example, one European directive in 1993 forecasted the study of all chemical substances produced or imported at a rate of more than 1,000 tonnes a year (there were 1885 of them). We have basic data for 14% of them, and only 5 substances have completed the risk evaluation process; for these 5 cases, significant changes to legislation have been requested, to protect consumers and workers! Faced with the slowness of the process, the European Union proposed a White Paper (February 2001) which will place the responsibility for risk evaluation on industry, by the year 2010 for substances of which more than 1,000 tonnes are produced, and by the year 2012 for those products of which 100 tonnes are produced.

This first necessary work will give us only a part of the answer, as it does not take into account the problem of co-exposure. All of these substances are, in fact, tested separately; now, human populations are exposed to many pollutants and we have no scientific tool with which to evaluate the effect of this co-exposure.

This only concerns chemical substances that are produced, and not products that result from industrial activities, such as particles or various atmospheric pollutants.

Thus, today we are largely unaware of the risk of most industrial products that exist in our daily environment – at home, at work, or outside.

Hence the notion of the principle of precaution, which consists of taking into account the unknown or poorly understood risks. This principle of precaution is different from the logic of prevention, which presupposes knowledge in order to intervene beforehand. We must act on the basis of elements of knowledge without the absolute certainty of the exposure-effect relationship.

One hundred years ago, it was Pasteur's revelation of the causality of "microbes" as regards infectious diseases that accelerated the implementation of preventive devices, long before having the medication to effectively fight "germs". This movement was considered a public health revolution, the first in history. Thus, it was through action on the environment (water conveyance and sewerage networks) that the major infectious pathologies were essentially mastered.

The revelation of the responsibility of chemical and physical agents for the considerable increase in chronic pathologies could constitute a ***second public health revolution***, whose consequences will be at least as important.

The challenge is to re-think the entire set of manufacturing processes and methods of use, in light of possible risks to human health.

In the next decade, the integration of the principle of precaution into national bodies of legislation (in Europe starting with the Maastricht Treaty, and in certain international agreements such as the Rio Treaty of 1992), as well as public pressure on rich countries, will accelerate the emergence of this second public health revolution.

What will be the fate of populations living in poor countries where the methods of industrial production are more dangerous, and where the notion of "acceptable risks" (a political – not scientific – notion), in the absence of structured public opinion, is palpably different from that of the countries of the North?

Who would be against a relocation, to the South, of at-risk factories adding the "new" environmental risks to the "old" ones?

Certainly, the major problems in the South come primarily from the first public health revolution. However, the example of the Pasteurian revolution shows that, in health protection, knowledge is not enough!

Medication

Medication has always accompanied the history of humanity. Its symbolic function as a "remedy", no matter what its real biological effectiveness, is a constant that is not likely to change in the future.

A number of essential medications, such as aspirin or quinine, appeared outside any modern scientific undertaking, and thus it probably would not have been possible to put them on the market if they had been discovered recently, given the technological and regulatory restrictions!

The evolution of scientific and technical knowledge drastically transformed the place of medication in health, but also in society as a whole, making medication an absolutely major economic and political challenge.

That medication must be truly biologically effective is an extremely recent notion, dating from the early 1980s. This idea of biological effectiveness is understood as the use of experimental, repeatable methods that allow the pharmacological action of an active principle on a given population to be proven. This approach, which we could call "modern", is very much supported by the rationalist paradigms that partly define our societies.

Thus, if we take this point of view, we know what constitutes medication, and what does not! Suddenly, the use of this high-technology product requires a minimum knowledge of its use and understanding of its operation; for example, the use of risk/benefit and cost/effectiveness relations.

Access to essential (or effective) medication presents – and will present more and more – two problems:

•An economic problem: the high cost of drugs protected by industrial patents; the non-production of certain essential medications (anti-parasite medicine, for example); and the insolvency of the populations that are the most in need of these medications.

•A problem of organisation: the absence of trained professionals for their prescription and/or issuance; access to the necessary information for their use; and the understanding of this information.

Thus, most antiretrovial medications against AIDS can be obtained in many African cities, but who will be capable of explaining their use, so that their benefits will outweigh the risks of their misuse? And who can pay for them?

Between 10 and 15 years are necessary to develop a marketable medication. Thus, today we can have an idea of the medications of tomorrow, and extrapolate the problems that will emerge. In this field, as in the whole biomedical field, true conceptual revolutions are being prepared, which are similar to an epistemological rupture.

Tomorrow's medications will strive for very high levels of qualitative and quantitative effectiveness; moreover, they will no longer be limited to the curative sphere.

After some twenty years, scientific methods allow us to contribute qualitative binary responses for an often very vast population under study; for example: is this intervention or that medication effective in this situation – yes or no?

Thanks to new experimental models, quantitative responses, by smaller and smaller population samples, with a tendency toward individuality, will be added to the qualitative binary response (yes or no). This means that if an intervention (a medication) is effective, we could say how effective it is, for a given person; in short, a medication will be extremely adapted to a particular person, suffering from a certain pathology.

To these innovations, we must add the use and development of new technologies such as genetic engineering, cell biology (stem cells), bio-informatics, and, again, new supports including traditional foods (bananas, milk, etc.) and tissues that, as they are added to traditional chemistry, will completely transform the face of medications.

The consequences can be very easily forecasted: the costs of research and production will increase considerably, and the sale price of medication as well. In France today, they cost close to 22.5 billion euros per year (150 billion French francs), about 15% of health spending, which itself represents about 10% of the GDP. At the minimum, the marketing budgets devoted to encouraging the purchase of the medications represent 15% of the business figures of this industry. In France, for example, this is close to 30,000 euros per year (200,000 French francs) and by physician's prescription. It is not unreasonable to imagine that all of these figures will be tripled within 20 years.

The pharmaceutical industries will be part of gigantic international conglomerates participating in extremely varied sectors, including the sector of information and communications, targeting the "general public" as well as professionals.

In the future, independent, quality information on medication, allowing us to get a real idea of the usefulness of one product or another, will be even more seriously threatened by the economic and financial weight of these industries, the legal framework of patent protection, and the scientific and technical complexity of future medications.

From this standpoint, social protection systems (health/disease sector) in rich countries will be susceptible to explosion in the medium term, and it goes without saying that the majority of humanity will be totally excluded from access to the medications of tomorrow, if the organisation of our societies remains in the state.

Food and Health

We need not be reminded of the importance of nutrition in health. The World Health Organisation estimates that half of humanity suffers from malnutrition, and more than a billion people suffer from excess weight or obesity. What are the new elements that will mark this field in the coming decades?

The industrialisation of food and meal preparation brings about qualitative modifications in food contributions, involving larger and larger populations. For technical and economic reasons, these preparations are fundamentally unequal, and their cost is low. Excess salt, fat, and sugar, for example, cause a proven increase in the risk for development of chronic illnesses, such as diabetes, hypertension and cardiovascular diseases, and even certain types of cancer.

The "classic" risk of infection (listeriosis, botulism, etc. – meaning, infections linked to poor quality of canning) is generally restricted by this industrialisation in developed countries, and "accidents" are primarily a reflection of violations of the law. This is not the case in the countries of the South, since they do not have the same level of legislation and penalties.

Nutritional deficiencies (although they are not new) remain a daily challenge to the health of the individuals and the development of the societies in the countries of the South. We should recall that malnutrition is quite often the result of the poor use of available food, and thus it is a question of education more than a question of the absence of the necessary quantity of these foods.

Addictive behaviours are classically attached to styles of feeding; they essentially concern alcohol, tobacco and medication. The tobacco industry, under legal and public pressure, is losing its European and North American markets. Its strategy is to invest in the markets of the South, notably in Asia and Latin America, where tobacco use by adolescents and women has exploded thanks to particularly successful marketing strategies.

The problem of addiction, particularly at the individual level, can raise complex approaches, mixing philosophy, culture, and society, for example. However, we should underscore the growing industrial character of the production of the majority of addictive products (legal as well as illegal), which uses all of the facets of industrial organisation (research and development, finance, marketing, etc.). This results in an increasingly massive over-representation of categories of consumers recruited from among the poorest and most uninformed populations.

The public is not very familiar with the enormous investments made in the chemistry of cigarettes with the sole goal of increasing consumer dependence, no matter what the cost in terms of morbidity/mortality. Revelations in this field, made possible by recent American trials against the tobacco industry, have shown the extent to which the heads of these industries are aware of the extreme harmfulness of their product. We have also been shown the existence of veritable strategies of misinformation aimed at stifling all inclinations of health education.

In the near future, the limits between foods and medications will become weaker and weaker: the concept of "pharmafood" already exists, and it will become a considerable challenge in the years to come. For example, it is theoretically possible that genetic manipulation could transform a banana into a vaccine with numerous valences (the equivalent to several vaccines).

It is also interesting to note that, at the global level, the leading industrial medication (and chemistry) groups are also the leading industrial groups in agriculture, with seeds, pesticides, GMOs, etc. This industry is by far the most profitable in the world. Just by memory, we can name the five most successful of these corporations, in decreasing order of profits (1999): DUPONT, MONSANTO, NORVATIS (Ciba/Geigy/Sandoz), ASTRA ZENECA, AVENTIS (Rhône-Poulenc/Hoechst).

Essential Health Information: Concept and Access

The statement that "AIDS drugs are in the North and the sick are in the South" demonstrates once again that our world industrial production system does not aim to meet needs – in this case, care for the sick – but rather to accumulate wealth and power, thereby leaving millions of people to die even though we have the remedies to treat them.

Nevertheless, not all of the arguments of the pharmaceutical industry are unacceptable. What is the principal motor that allows people to work hard in researching and discovering new molecules? Where are the modern, effective molecules found by Soviet and Chinese research? The development of a drug, its production, distribution, quality controls – everything has its cost. Who must pay, and what must they pay?

In the North, it is society as a whole that pays, no matter what the systems are, be it medical insurance or national health care. It is financial solidarity that allows for the funding of industry and its research, and that allows it to make profits, which over time have become the highest of all industrial branches. The importance of these profits, which are guaranteed by a solidarity system, must lead us to reflect on the notion of "reasonable profit" that is compatible with maintaining the solidarity that is its source, and minimum ethics on a global scale. Must the net profit after production costs (including research costs), be 15%, 150%, 1500%, or more?

In many situations, when medication is necessary, it is no less insufficient; the organisation of the health system and access to essential health information, for both health professionals and the population, are just as important. These universal questions are particularly important in the South, and now in Eastern Europe as well, as the waste of available resources in those countries has immediate consequences in terms of mortality and morbidity.

Quality information – meaning, information that is adapted to its user, scientifically validated and "non-biased" by conflicts of interest, presents us with the same challenges as medication: every day in our world, people die because they and their health providers did not have the "right information".

That, in the North, a professional could theoretically be sued for incompetence is only a paltry consolation for victims!

Should we refute the problem under the pretext of a freedom to choose one's physician, while this freedom is to this point obscured by its absence, given the voluntary withholding of information at all levels? Must the patients of those who do not have means to access essential information be the victims of a system that surpasses them? And in any case, how can they know!?

Populations, health professionals, policy-makers and technical specialists face increasing difficulties in accessing this "essential information" on health.

There are many reasons for this: the profusion of information, often commercial; the concentration of information producers and the control of this information by health care product manufacturers or others (food, water, chemistry, etc.); multiple conflicts of interest and resignation of those in charge; the cost of producing quality information; and linguistic obstacles.

For health professionals, there is also deficient intellectual training (ethical, critical thinking, competency strategy, etc.) and the considerable weight of lobbyists.

Quality biomedical journals, almost always in English, are financially out of the reach of most health professionals in the world; this is a relatively large effort even for rich countries, given the high price of subscription.

Those who pay for subscriptions to these quality journals out of their own pocket must first be convinced of this need, when their entire environment pushes them toward being satisfied with pharmaceutical marketing.

Moreover, some of these major journals are beginning to seek profits, either spontaneously or because they have fallen under the control of industrial groups. The 1999 dismissal of the editors-in-chief of two of the main world medical journals (the JAMA and the NEJM) are examples to think about.

We should ask the same questions as in the case of essential medication: who should pay? What should they pay? If we are speaking of quality information, necessarily independent of health industries at least, we should note that there is also a cost for production, distribution, and quality control, as well as questions about intellectual property protection, etc.

In the North, the cost of therapeutics and the organisation of the system are collective; why would it not be the same for access to essential information? Why should those living in the South not have access to vital information, which would save so many lives?

Observation of the different systems of the European Union shows that collectivity does not necessarily mean public or State power, but in all cases profit is not sought. If health should not be a market, and if it requires collective funding to ensure Solidarity and Quality, then access to information must be able to be funded by the collective as well.

The WHO has just made an agreement with publishers of biomedical journals, to provide free access to these journals on the Internet starting in (Communiqué WHO/32 of 9 July 2001).

At the beginning of the year 2001, a movement initiated by American researchers threatened to boycott scientific journals that did not respond to their demands for facilitation of access to articles, arguing that generally research ending in articles is publicly funded and the copyright is given to private publishers. Their petition obtained 26,000 signatures from 170 countries (see *Le Monde* 20 April 2001). Following this movement, one of the main American databases ("Medline") just decided to provide free access to its articles.

We must go further. In the health field, we must define a "list" of essential information that must be made public, in an understandable manner, such as the list of essential medications. Production, distribution, quality controls, translations – all of this must be collectively funded, just as the reimbursement by the health care system.

As with essential medications, developed countries must contribute towards the inclusion of the countries of the South in the battle for access to essential information, beginning with health professionals.

This strategic battle largely surpasses the field of preventive and curative medicine. The list of essential information must include information on health and the environment, as well as food. It must involve health professionals as well as information professionals, for whom the concept of independence assumes the same challenges.

Just like in any battle, alliances must be thought out in relation to objectives. States – and, in France, the "Assurance Maladie" (alias Social Security) – must not be considered *a priori* enemies, as they do not defend the profit-oriented point of view. We admit, however, that it is not evident when we consider the policies of our latest French governments, in the self-same area of medication.

In this respect, professional corporatisms are much more suspect, in light of the ambiguous relationships between health industries and our leaders of medical opinion.

Conclusion

The majority of the world population, which lives outside the thirty richest countries, will continue to suffer the consequences of infectious plagues and degraded food quality, with an increase in addictive behaviours teleguided by effective marketing and the "*second public health revolution*", while being kept from the essential medications that could immediately save many lives.

Already, large areas of the planet (such as Africa and Eastern Europe) are experiencing a significant decrease in the life expectancy of their populations, while, every four years, that of the rich countries increases by one year.

At the same time, in the rich countries, socio-cultural inequalities in terms of health are progressing more quickly than the general increase of life expectancy.

Those who suffer the noxious effects of a degraded environment at home or at work also face risk factors.

Moreover, the cost of new medications is liable to cause an explosion in health insurance systems, forcing quite a significant population into the same situation being experienced by more disadvantaged countries, a situation that is already being observed in the USA.

For each of the areas addressed here, ***access to essential information*** – meaning "adapted and understandable", scientifically "validated", non-biased by financial and/or corporatist conflicts – constitutes the terrain of a major strategic battle in which the supporters of absolute liberalism have gained ground.

Proposals

In the Area of Health and the Environment

1) To develop research and risk evaluation of industrialised products at all levels.

-To create autonomous continental agencies with significant human and financial means to be in charge of risk evaluation;

-To create continental or national agencies responsible for sales and control.

2) To develop clear, informative labelling on all products sold.

3) To establish and publicise the risk zones created by past and present industrial activities; and to encourage, in this field, multinational, co-operative work to circumvent intra-national pressures to remain in the dark.

4) To train health professionals in this issue.

In the Area of Medication

1) To establish one or more databases on medication, independent of the world of industry and finance, simple, understandable and accessible to everyone in their own language. In these databases, the data would be internationally scientifically valid. The main vector of this database could be the Internet.

2) To re-think and invent new processes of industrialisation of medication that would make it possible to remain effective in the discovery of new remedies, and be accessible to those who need it.

In this framework:

- To encourage, in each important population basin, “medical self-sufficiency” for the transfer of knowledge and know-how;
- To particularly encourage, in each important population basin, the production of medication that is not protected by copyrights, under the control and management (delegated or not) of a public authority (WHO?).

Reference to the Debate on the World Trade Organisation and the Protection of Intellectual Property.

NB: This proposal is complementary of the need to also re-think the forms of funding for social protection. Fundamentally, even with a system of mutualisation of spending (collective funding of the expenditures related to a risk), it is no longer acceptable to see the price of medication (which is very high) completely disconnected from the real costs of production (which are very low). Research and development costs cannot justify such a gap, as they are “insured”, before and after, by the creditworthiness of consumers in health insurance systems.

3) Prohibit rich countries from exporting medications that are prohibited from being sold in their own territories (with appropriate mechanisms for exceptions).

4) Implement mechanisms to encourage research on “indigent” drugs, as much as “orphan” drugs.

Reference to Proposals by Doctors Without Borders.

NB: An “orphan” drug is aimed at caring for an “orphan” illness; its name comes from the fact that is extremely rare. From the industrial point of view, the fact that it is rare makes it uninteresting to develop molecules to treat it, as it is not financially profitable.

As an analogy, “indigent” drugs are those that are used to care for illnesses that mainly affect insolvent populations. These illnesses, which include parasites in tropical areas, often affect hundreds of millions of people.

In the Area of Food

The proposals already developed on other theme
policy”.

1) Priority educational strategies on food and nutrition, particularly for children.

2) Clear, simple product labelling.

3) Organisation of multi- in industrial foodstuffs
( ).

Cross-

Organising the independence of health professions.

This is a major strategic challenge:

the point of view of the caregiver, the purpose of medicine is not profit, but rather the struggle against suffering and disease, both preventive and curative.

We must avoid corporatist structures like France’s “Ordre des médecins”
Doctors), which was especially incapable of preserving the independence of physicians in this country.

It is not a question of union structures, either, as these play a different role.

It is a question of _____ and demo____ structures that are capable of influencing initial and continuing training in ethics, and which are capable of mutualising experiences for regular

alth professions, that
international exchanges (the majority of which are funded by the medication industry) are almost

clinics, while the simple mutualisation of experiences of others would have a strong dynamic.

2) For a policy on access to "essential information" based on the model of policy on access to essential medication.

This policy includes several levels:
The "targets": the general population, and specific populations such as health professionals, journalists, educators, politicians, etc.
The themes: health and medication, food and nutrition, health and the environment.

There are many examples where the more or less voluntary withholding of information has caused losses of life and quality of life (the asbestos affair, salt in foodstuffs, Sudden Infant Death Syndrome, folic acid supplements in pregnant women, nursing, etc.), even in rich countries.

The conflict of interest in most of the media, between information and media owners, but also the high price of access to quality information, are the main obstacles to the dissemination of essential information.

Access to essential information is a fundamental condition for health democracy – meaning, the involvement of all individuals in the process of collective decision-making on individual and public health.

2 bis) Creation of legal devices to punish deliberate misinformation campaigns about "essential information".

3) To develop mutualist models for health funding that are applicable to the communities that want it, where there is no social protection system, allowing for a dissociation between a community's level of wealth and its health solidarity action. In other words, to show that no matter what the level of income, a health policy can be effective within a group as long as certain rules and restrictions are applied.