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H. RES. 204

Honoring the life of Dr. Paul Farmer by recognizing the duty of the Federal Government to adopt a 21st-century global health solidarity strategy and take actions to address past and ongoing harms that undermine the health and well-being of people around the world.

IN THE HOUSE OF REPRESENTATIVES

MARCH 7, 2023

Ms. SCHAKOWSKY (for herself, Ms. LEE of California, Mr. RUIZ, Mr. BLUMENAUER, Mr. CARSON, Mr. COHEN, Mr. DOGGETT, Mr. ESPAILLAT, Mr. GARCÍA of Illinois, Ms. JACKSON LEE, Ms. JAYAPAL, Ms. MCCOLLUM, Mr. MCGOVERN, Mr. MOULTON, Ms. NORTON, Ms. PORTER, Ms. PRESSLEY, Ms. ROSS, Mr. SOTO, Ms. TLAIB, Mr. TRONE, and Mrs. WATSON COLEMAN) submitted the following resolution; which was referred to the Committee on Foreign Affairs, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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RESOLUTION

Honoring the life of Dr. Paul Farmer by recognizing the duty of the Federal Government to adopt a 21st-century global health solidarity strategy and take actions to address past and ongoing harms that undermine the health and well-being of people around the world.

Whereas Dr. Paul Farmer, who pioneered novel community-based strategies for the delivery of high-quality health care in impoverished settings, inspired a paradigmatic shift in global health, including inspiring robust United

States leadership to address the global HIV/AIDS epidemic in the early 2000s via the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria;

Whereas, in spite of this progress, weak health systems continue to cause millions of people, primarily the global poor, to die tragic and unnecessary deaths, including—

(1) annually, approximately—

(A) 680,000 deaths from HIV/AIDS;

(B) 1,500,000 deaths from tuberculosis;

(C) 627,000 deaths from malaria;

(D) 295,000 deaths of mothers during and following pregnancy and childbirth;

(E) 9,560,000 deaths among children under the age of 15; and

(F) 560,000 deaths of children and young adults living among the world's poorest billion people from noncommunicable diseases and injuries; and

(2) a COVID–19 case-fatality rate up to 300 percent greater in low-income countries than in high-income countries during the first two years of the SARS–CoV–2 pandemic;

Whereas, although progress against unnecessary deaths in impoverished countries is being made, it is occurring so slowly that—

(1) based on present rates of decline, it will take approximately a century for core mortality statistics in low-income countries to converge with those of high-income countries, including—

(A) 92 years for the tuberculosis death rate;

(B) 109 years for the maternal mortality rate; and

(C) 88 years for the under-15 child mortality rate; and

(2) the death rate in low- and middle-income countries from noncommunicable diseases and injuries, which make up 40 to 60 percent of the disease burden of these countries, will never converge with that of high-income countries with present rates of reduction;

Whereas weak health systems that fail to prevent unnecessary deaths also lack the staff, health facility infrastructure, and medical technologies required for effective care delivery and thereby disease containment, thus placing all countries at increased risk of pandemic disease;

Whereas essential medical technologies such as diagnostics, treatments, and vaccines for diseases that affect the global poor are frequently unavailable or inaccessible to health systems in developing countries because—

(1) investing in research and development for technologies for diseases that disproportionately affect the global poor is often unprofitable for pharmaceutical corporations;

(2) high intellectual property licensing fees from originator companies to generic manufacturers price the global poor out of access to medical technologies; and

(3) originator technology companies refuse to share or license intellectual property to generic manufacturers, which results in limited supply and high prices, as in the case of COVID–19 vaccines;

Whereas the Lancet Commission on Investing in Health estimates the additional annual spending required to prevent the vast majority of the millions of unnecessary deaths

and confer ''essential universal health coverage'' in low- and lower-middle-income countries is $75,000,000,000 and $293,000,000,000 (in 2016 United States dollars), respectively, representing just—

(1) 1.6 percent of the United States gross domestic product (GDP) in 2021;

(2) 0.5 percent of G20 GDP in 2021; and

(3) 2.8 percent of the wealth possessed by the world's billionaires in 2021;

Whereas regular annual United States appropriations for global health have increased by merely 10.6 percent to $11,300,000,000 since 2010, and have been outpaced by both inflation and the United States economic growth;

Whereas relative to the size of the United States economy, the United States official overseas development spending is low at 0.17 percent of gross national income (GNI) in 2020, placing the United States 24th out of the 29 country members of the Organization for Economic Co-operation and Development's Development Assistance Committee, and meeting just one-fourth of the United Nations official development assistance target of 0.7 percent GNI;

Whereas dramatically increasing foreign aid may have voter support, given that opinion polls consistently find that Americans believe United States foreign aid should make up approximately 10 percent of the Federal budget;

Whereas historically, United States and other global North-supported global health programs have inadvertently entrenched standards of care in low-income countries that would be unacceptable in rich countries by funding only health services narrowly defined as ''sustainable'', ''cost-effective'', or ''appropriate'' in poor settings;

Whereas the effectiveness and efficiency of current United States overseas development assistance for health is often undermined by—

(1) misalignment with countries' national health plans;

(2) bypassing delivery systems with parallel inputs, leading to fragmentation of care delivery, poor donor coordination across partners, and weak health systems;

(3) favoring technical assistance from consultants from high-income countries, especially the United States, over funding health service delivery in beneficiary countries; and

(4) promoting privatization of health services, thereby undermining public system strengthening, health care access, health equity, and financial risk protection;

Whereas 98 percent of the annual $1,500,000,000,000 in health spending in aid-eligible low- and middle-income countries is mobilized domestically by these countries themselves, and only 2 percent of this spending comes from overseas development assistance for health;

Whereas many of the poorest developing countries presently lack the tax capacity to mobilize the necessary resources to close the universal health coverage financing gap, meaning unnecessary deaths will continue in these settings for the foreseeable future without external donor financing or dramatic increases in domestic tax capacity;

Whereas the inability of many of the poorest developing countries to fully close the financing gap for universal health coverage and the provision of numerous other public goods and services is in part due to the intimate economic links between these countries and high-income countries, including the United States, which have been

marked throughout history by acts of violence and coercion, including, but not limited to—

(1) the fundamental injustice, cruelty, brutality, and inhumanity of colonization and slavery;

(2) the overthrow of governments and backing of dictatorships in the postcolonial era;

(3) the imposition of structural adjustment programs by international financial institutions controlled by high-income countries, which forced austerity, privatization, and liberalization on developing countries, resulting in an estimated loss of $480,000,000,000 per year in potential GDP during the 1980s and 1990s, nearly 5 times more than aid provided during the same period;

(4) the loss of economic sovereignty imposed by fundamentally undemocratic global governance institutions, such as the International Monetary Fund, the World Bank, and the World Trade Organization, at which decisions that shape the unequal terms of the global economic system and determine countries' abilities to finance health systems are made;

(5) capital flight from developing countries consisting of mostly illegal financial flows, estimated by Global Financial Integrity to total approximately $1,700,000,000,000 each year, including—

(A) $700,000,000,000 from deliberate trade misinvoicing; and

(B) $261,000,000,000 from hot money narrow outflows; and

(6) external debt repayments, often undemocratically and unjustly imposed, commonly sold by corrupt lenders, regularly accumulated by dictators without a democratic mandate, and exacerbated by compound interest as a result of United States interest rate increases;

Whereas the harms have entrenched a global economic architecture of upward wealth redistribution that has resulted in—

(1) depressed workers' wages and artificially low prices of natural resources in developing countries to serve consumption in rich countries, amounting to an appropriation of tens of billions of tons of raw materials and hundreds of billions of hours of human labor, estimated to value over $10,000,000,000,000 in losses through unequal exchange annually;

(2) 3,500,000,000 people living under the poverty line of $5.50, which according to the World Bank is a poverty headcount that has ''barely changed in the last 30 years'', even as global GDP has more than tripled in size during this time;

(3) more financial resources flowing out of developing countries than into them each year, estimated by Global Financial Integrity to total net negative $2,000,000,000,000 annually in 2012, meaning poorer countries are developing richer countries rather than the other way around; and

(4) developing countries bearing 98 percent of deaths and 80 to 90 percent of economic losses attributable to climate change, despite rich countries bearing 92 percent of the responsibility for climate change due to carbon emissions in excess of safe planetary boundaries, meaning those who suffer the most from climate change are least responsible for the crisis;

Whereas the United States leadership to close the financing gaps for essential universal health coverage in low- and lower-middle-income countries could precipitate increased global health financing from other donor partners as evidenced by United States leadership to address the HIV/

AIDS epidemic in the early 2000s, spurring a 100-percent increase in global overseas development assistance among all donor partners from 2000 to 2006;

Whereas official United States development assistance to low- and lower-middle-income countries are not a supplement for United States action to stop ongoing structural violence and economic injustices preventing countries from financing and delivering universal health care and other social services for their populations; and

Whereas it is the view of the House of Representatives that creating a decent, humane world without tragic, unnecessary deaths requires both a modest but meaningful increase in global health aid funding and a meaningful effort to stop the economic abuse of low- and middle-income countries: Now, therefore, be it

(1) the Federal Government should adopt a new, 21st-century global health solidarity strategy to end medically avertable deaths and respond to the full burden of disease in poor countries by—

(A) supporting developing countries to meet the material needs of their health systems by localizing investments in support of national public sector and local priorities, referred to as ''accompaniment'' by Dr. Paul Farmer and delivered through what he called the ''Five S's'', which include—

(i) staff, the human resources necessary for high-quality service delivery, in-

cluding clinical staff, transportation teams, and community health workers, especially by—

(I) supporting long-term training and education systems, including medical schools and teaching hospitals to train the health workforce and improve the quality of care across diseases; and

(II) supporting professionalized community health workers programs whereby community health workers are recruited, adequately compensated, comprehensively trained, supported for long-term retention, positioned as bridges to care, and tasked with undertaking community work with appropriate patient ratios and a manageable scope of work;

(ii) space, the infrastructure needed for service delivery at primary, secondary, and tertiary levels to deliver safe and high-quality care to meet all health care needs;

(iii) stuff, the tools and resources necessary for high-quality care provision, in-

cluding medical supplies, technologies, and equipment;

(iv) systems, the leadership and governance, health information systems, supply chain systems, logistics, laboratory capacity, and referral pathways required to meet the health needs of the population; and

(v) social support, the necessary resources needed, beyond the direct delivery of health care, to ensure effective care; and

(B) financing the discovery and development of urgently needed new health technologies such as diagnostics, treatments, and vaccines, particularly for neglected diseases of poverty, and ensuring their availability as global public goods;

(2) the objectives described in paragraph (1) will require—

(A) increased United States investment in development assistance over the coming years, sufficient to—

(i) for the first time, meet the United Nations development assistance target of spending the equivalent of 0.7 percent

gross national income on development assistance, which 6 other countries have previously met; and

(ii) close over 100 percent of the previously described essential universal health coverage financing gap for low-income countries, and 30 percent of the overall financing gap for low- and lower-middle-income countries, by dedicating $125,000,000,000 per year for global health investment;

(B) optimizing global health delivery spending by—

(i) introducing a new form of coordinated multilateral fiscal cooperation for global public investment that ensures increased and ongoing global public funding of common goods for health, exhibiting shared governance with global South governments and meaningful participation of civil society, which is also essential for addressing intersectional crises of social inequalities including the climate crisis;

(ii) ensuring funding directly supports national health plans, public institutions,

local priorities, and donor coordination, practices aligned with what Dr. Paul Farmer called ''accompaniment''; and

(iii) focusing on health service delivery for vulnerable populations, such as people living in poverty, women, and children; and

(C) optimizing research and development spending for neglected diseases of poverty by ensuring the knowledge and technology produced by these efforts remains accessible to all as global public goods;

(3) the Federal Government should pass and enforce laws and use its diplomatic influence to stop ongoing economic harms to the global South that deplete impoverished countries of the resources required to provide health and social services for their populations by—

(A) canceling debt for all low- and middle-income countries in need of debt cancellation, and supporting debt cancellation initiatives across all creditors: bilateral, multilateral, and private;

(B) democratizing institutions of global governance, such as the International Monetary Fund, the World Bank, and the World Trade

Organization, to ensure fair and equal representation among member countries so that low- and middle-income countries can have greater decisionmaking power in the creation of policies that affect them;

(C) supporting a United Nations Convention on Tax and other measures to dramatically reduce tax avoidance, tax evasion, and other forms of harmful licit and illicit financial flows from developing countries through fundamental reform of international tax cooperation;

(D) supporting global labor rights and living wages, such as a global minimum wage set at local living-income thresholds; and

(E) adopting new indicators of progress that measure social and ecological health and abandon gross domestic product as a measure of progress; and

(4) it is the duty of the Federal Government to issue reparations, containing multiple elements including apology, award, and guarantees of nonrepetition of harms, for—

(A) the institution of slavery, its subsequent racial and economic discrimination against African Americans, and the impact of

these forces on living African Americans, following the establishment of a commission as per the ''Commission and Develop to Study Reparation Proposals for African Americans Act'' (H.R. 40 of the 117th Congress);

(B) the harms of colonialism and subsequent forms of imperialism, which have undermined sovereignty, democracy, self-determination, social and economic rights, and human and ecological well-being in both the colonial and postcolonial eras; and

(C) its disproportionate responsibility for climate breakdown, the burden of which unjustly and overwhelmingly falls on the global South.

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