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S. RES. 358

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 SENATE OF THE UNITED STATES

JULY 31, 2025

Mr. MARKEY (for himself and Ms. WARREN) submitted the following resolution; which was referred to the Committee on Foreign Relations

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 through the United States President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis, and Malaria;

Whereas, in spite of progress made in global health, 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 poorest billion people in the world, from non-communicable diseases and injuries; and

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

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

(1) based on rates of decline from 2013 to 2022, 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 non-communicable diseases and injuries, which make up 40 to 60 percent of the disease burden of those countries, will never converge with that of high-income countries based on rates of reduction from 2013 to 2022;

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 disease containment, 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 of technologies for diseases that disproportionately affect the global poor is often unprofitable for pharmaceutical corporations;

(2) costly intellectual property licensing fees from originator companies to generic manufacturers frequently leave the global poor unable to purchase or access medical technologies; and

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

Whereas, according to the Lancet Commission on Investing in Health, preventing most avertable deaths and conferring “essential universal health coverage” in low- and lower-middle income countries requires an increase in annual health systems resources in those countries of

\$75,000,000,000 and \$293,000,000,000 (in United States dollars as of 2016), respectively;

Whereas, historically, the 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 the national health plans of the host country;

(2) bypassing delivery systems with parallel inputs, leading to—

(A) fragmentation of care delivery;

(B) poor donor coordination across partners;

and

(C) 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, which weakens—

(A) the public health system;

(B) health care access;

(C) health equity; and

(D) 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 the countries themselves, and only 2 percent of this spending comes from overseas development assistance for health;

Whereas many of the poorest developing countries lack the tax capacity to mobilize the necessary resources to close the universal health coverage financing gap, meaning unnecessary deaths will continue in the poorest developing countries 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 those countries and high-income countries, including the United States, which have been marked throughout history by acts of violence and coercion;

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

(1) depressed wages of workers and artificially low prices of natural resources in developing countries, amounting to an appropriation of tens of billions of tons of raw materials and hundreds of billions of hours of human labor through unequal exchange;

(2) 3,500,000,000 people living under the poverty line of \$5.50 from 1993 to 2023, even as global gross domestic product has more than tripled in size during this time;

(3) more financial resources flowing out of developing countries than into developing countries each year,

estimated by Global Financial Integrity to total a net negative of \$2,000,000,000,000 annually in 2012; and

(4) developing countries bearing nearly all deaths and the vast majority of economic losses attributable to climate change, despite rich countries bearing 92 percent of the responsibility for climate change;

Whereas leadership from the United States 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 that addressed the HIV/AIDS epidemic in the early 2000s, which spurred a 100-percent increase in global overseas development assistance among all donor partners from 2000 to 2006;

Whereas official United States development assistance to lower-middle income countries is 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 Senate 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 *Resolved*, That it is the sense of the Senate that—
- 2 (1) the Federal Government should adopt a
- 3 new, 21st century global health solidarity strategy to

1 end medically unnecessary deaths and respond to the
 2 full burden of disease in poor countries by—

3 (A) supporting developing countries to
 4 meet the material needs of their health systems
 5 by localizing investments in support of national
 6 public-sector and local priorities, referred to as
 7 “accompaniment” by Dr. Paul Farmer, and de-
 8 livered through what Dr. Paul Farmer called
 9 the “Five S’s”, which refers to—

10 (i) staff, meaning the human re-
 11 sources necessary for high-quality service
 12 delivery, including clinical staff, transpor-
 13 tation teams, and community health work-
 14 ers, especially by—

15 (I) supporting long-term training
 16 and education systems, including med-
 17 ical schools and teaching hospitals to
 18 train the health workforce and im-
 19 prove the quality of care across dis-
 20 eases; and

21 (II) supporting professionalized
 22 community health worker programs
 23 whereby community health workers
 24 are recruited, adequately com-
 25 pensated, comprehensively trained,

1 supported for long-term retention, po-
 2 sitioned as bridges to care, and tasked
 3 with undertaking community work
 4 with appropriate patient ratios and a
 5 manageable scope of work;

6 (ii) space, meaning the infrastructure
 7 needed for service delivery at primary, sec-
 8 ondary, and tertiary levels to deliver safe
 9 and high-quality care to meet all health
 10 care needs;

11 (iii) stuff, meaning the tools and re-
 12 sources necessary for high-quality care pro-
 13 vision, including medical supplies, tech-
 14 nologies, and equipment;

15 (iv) systems, meaning the leadership
 16 and governance, health information sys-
 17 tems, supply chain systems, logistics, lab-
 18 oratory capacity, and referral pathways re-
 19 quired to meet the health needs of the pop-
 20 ulation; and

21 (v) social support, meaning the re-
 22 sources needed, beyond the direct delivery
 23 of health care, to ensure effective care; and

24 (B) financing the discovery and develop-
 25 ment of new, urgently needed health tech-

1 nologies, such as diagnostics, treatments, and
 2 vaccines, particularly for neglected diseases of
 3 poverty, and ensuring their availability as global
 4 public goods;

5 (2) the objectives of adopting a 21st century
 6 global health solidarity strategy to end medically un-
 7 necessary deaths and responding to the full burden
 8 of disease in poor countries will require—

9 (A) increasing annual global health spend-
 10 ing to \$125,000,000,000, sufficient—

11 (i) for the first time, to meet the
 12 United Nations development assistance
 13 target of spending the equivalent of 0.7
 14 percent gross national income on develop-
 15 ment assistance, which 6 other countries
 16 have previously met; and

17 (ii) to close over 100 percent of the
 18 essential universal health coverage financ-
 19 ing gap for low-income countries, and 30
 20 percent of the overall financing gap for
 21 low- and lower-middle income countries;

22 (B) optimizing global health delivery
 23 spending by—

1 (i) introducing a new form of coordi-
 2 nated, multilateral fiscal cooperation for
 3 global public investment that—

4 (I) ensures increased and ongo-
 5 ing global public funding of common
 6 goods for health; and

7 (II) exhibits shared governance
 8 with global South governments and
 9 meaningful participation of civil soci-
 10 ety, which is also essential for ad-
 11 dressing intersectional crises of social
 12 inequalities including the climate cri-
 13 sis; and

14 (ii) ensuring funding directly supports
 15 national health plans, public institutions,
 16 local priorities, and donor coordination,
 17 practices aligned with what Dr. Paul
 18 Farmer called “accompaniment”;

19 (C) focusing on health service delivery for
 20 vulnerable populations, such as—

21 (i) people living in poverty;

22 (ii) women; and

23 (iii) children; and

24 (D) optimizing research and development
 25 spending for neglected diseases of poverty by

1 ensuring the knowledge and technology pro-
2 duced by these efforts remains accessible to all
3 as global public goods;

4 (3) the Federal Government should pass and
5 enforce laws and use its diplomatic influence to stop
6 ongoing economic harms to developing countries that
7 deplete impoverished countries of the resources re-
8 quired to provide health and social services for their
9 populations by—

10 (A) supporting debt cancellation initiatives
11 for low- and middle-income countries, particu-
12 larly countries in need of debt cancellation,
13 across bilateral, multilateral, and private credi-
14 tors;

15 (B) democratizing institutions of global
16 governance, such as the International Monetary
17 Fund, the World Bank, and the World Trade
18 Organization, to ensure fair and equal represen-
19 tation among member countries so that low-
20 and middle-income countries can have greater
21 decisionmaking power in the creation of policies
22 that affect them;

23 (C) supporting a United Nations Conven-
24 tion on Tax and other measures to dramatically
25 reduce tax avoidance, tax evasion, and other

1 forms of harmful licit and illicit financial flows
2 from developing countries through fundamental
3 reform of international tax cooperation;

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

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

11 (4) it is the duty of the Federal Government to
12 issue reparations, containing multiple elements, in-
13 cluding apology, award, and guarantees of non-rep-
14 etition of harms, for—

15 (A) the institution of slavery, the subse-
16 quent racial and economic discrimination
17 against African Americans that resulted from
18 the institution of slavery, and the impact of
19 these forces on living African Americans, fol-
20 lowing the establishment of a commission sub-
21 stantively similar to the commission established
22 under the Commission to Study Reparation
23 Proposals for African Americans Act, H.R. 40,
24 as introduced on January 4, 2021;

- 1 (B) the harms of colonialism and subse-
2 quent forms of imperialism, which have under-
3 mined sovereignty, democracy, self-determina-
4 tion, social and economic rights, and human
5 and ecological well-being in both the colonial
6 and post-colonial eras; and
- 7 (C) the disproportionate responsibility of
8 the Federal Government for climate breakdown,
9 the burden of which unjustly and overwhelm-
10 ingly falls on the global South.

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