



Access to Reproductive Health in a Neoliberal Policy Climate
A research paper by Family Planning International intern, Emily Sandusky
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Introduction

The 1994 International Conference on Population and Development Programme of Action (ICPD PoA) established guidelines for achieving human rights-centred population and development goals, specifically universal access to sexual and reproductive health care services and information by 2015. The development landscape is strongly shaped by economic ideology, particularly that of neoliberalism. Thus, it is important to understand the ways in which key policies, such as World Trade Organization agreements and health sector reforms implemented by the IMF and World Bank, impact the achievement of reproductive health goals outlined in the ICPD PoA.

This report focuses on the relationship between policies implemented by the WTO, World Bank and IMF and access to affordable health care, particularly sexual and reproductive health care services and information as defined by the ICPD PoA. The first section provides a context for the discussion of neoliberal global finance policies and access to sexual and reproductive health care services (SRH) by giving a brief historical account of the ICPD PoA, and the WTO, World Bank and IMF. The second section focuses on past and current health sector reforms implemented by the World Bank and IMF including reforms introduced in Structural Adjustment Programs. The third section describes the ways in which WTO agreements, specifically TRIPS and GATS, affect access to reproductive health care services outlined in the ICPD PoA.

Part I Context

International Conference on Population and Development Program of Action

The International Conference on Population and Development (ICPD) was held in Cairo in 1994. More than 180 States and 11,000 registered participants worked together to create the landmark Cairo Programme of Action (PoA), a guide for national and international action in the areas of population and development during the next 20 years. The PoA marked a shift from a quota-based approach to population policy to human rights-based strategies that “emphasize the integral linkages between population and development and focus on meeting the needs of individual women and men, rather than meeting demographic targets.”¹

The PoA moves beyond a population strategy solely based on family planning services. It is a framework for providing women with resources for making decisions regarding their reproductive health through expanded access to health services, education, skill development, employment, and full involvement in policy- and decision-making processes.

A primary goal of the PoA is to make reproductive health care universally available through the primary health care system to all individuals of appropriate ages by the year 2015. Additional PoA goals include increased access to education, particularly for girls, and reduced levels of infant, child, and maternal mortality. The PoA also highlights concerns including: issues relating to population, the environment, and consumption patterns; internal and international migration; prevention and treatment of HIV and AIDS; research and development of new technologies; and strengthening partnership with non-governmental organisations.

Reproductive Health, Health Care, and Rights

The PoA's 2015 target for universally available reproductive health care is informed by its comprehensive definitions of reproductive health, reproductive health care and reproductive rights. Reproductive health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."² As defined in the ICPD PoA, reproductive health implies a satisfying and safe sex life, freedom to decide if, when and how often to reproduce, including choices regarding fertility regulation methods and access to health care services that will provide the best chance of having a safe pregnancy and childbirth, and a healthy infant.

In the PoA, reproductive health care is defined as the "constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems."³ The PoA specifically outlines the scope of its goals for universal access to reproductive health care by 2015. First, reproductive health care services and information should be accessible through the primary health care system. Further, reproductive health services should cater to the needs of adolescents as well as women of childbearing age. Education and counselling are to take a primary role along with treatment and services. According to the PoA, reproductive health care services should include: family planning; prenatal care, delivery, and post natal care, especially breast-feeding and infant care; prevention and treatment of infertility; treatment of reproductive tract infections and sexually transmitted infections; and referrals for further diagnosis and treatment including that for HIV and AIDS, breast cancer and cancers of the reproductive system.

The PoA's definitions of reproductive health and health care are grounded in an understanding of reproductive rights as basic human rights already recognised by national and international human rights documents. These include: the right of couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and support services to do so; the right to attain the highest standard of sexual and reproductive health (SRH); and the right to make personal reproductive health decisions free from discrimination, coercion or violence.

Millennium Development Goals

The United Nations' Eight Millennium Development Goals (MDGs) comprise the global framework for poverty reduction. When the UN adopted the MDGs in 2000, there was no specific goal or target reflecting the ICPD PoA's plan for universal access to reproductive health care by 2015. In October 2006, after calls from NGOs, governments and other organisations for increased UN commitment to reproductive health, the General Assembly adopted the PoA's aim to make reproductive health care universally accessible by 2015 as a specific target under Development Goal Five, the reduction of maternal mortality. As the MDGs are central to global poverty reduction strategies, the

UN's decision to include the achievement of universal access to reproductive health care reinforces the importance of financial and political support for reproductive health care in poverty reduction efforts.

The Bretton Woods Trio

The goal of the Bretton Woods conference, held in 1944, was to build a new framework for the international global economy. Following the global economic depression of the 1930s and World War II, the participants at the Bretton Woods conference sought to create a stable international monetary system that would promote national sovereignty and prevent future financial crises. Three international governing bodies, collectively known as the Bretton Woods institutions, emerged from the conference: the International Monetary Fund (IMF); the International Bank For Reconstruction and Development which later became widely known as the World Bank; and the General Agreement on Tariffs and Trade (GATT), which in 1995 grew to become the World Trade Organization or WTO.

The IMF's original mission was to create post-war economic stability by overseeing a system of fixed exchange rates, promoting currency convertibility for ease in international trade, and providing emergency loans.

The World Bank was initially developed to aid in the rebuilding of European economies devastated by WWII by providing loans for economic infrastructure like power plants, dams, roads, airports, agricultural development and education systems. As Europe recovered in the 1950s, the World Bank turned its attention to funding infrastructure projects in the Latin America, Asia, and Africa. Even with fairly low interest rates, poor countries had difficulty repaying loans. In response, the World Bank was pressured, in the late 1950s, to set up the International Development Association (IDA) which provides 'soft loans' with little or no interest.

The General Agreement on Trade and Tariffs (GATT) was established to govern global trade and, in particular, to reduce the national trade barriers and competitive trade policies that were blamed for the weak global economy prior to WWII. In 1994, the World Trade Organization (WTO) replaced GATT. The WTO includes the GATT agreements as well as the General Agreement on Trade in Services (GATS), and the Trade Related Aspects of Intellectual Property Rights (TRIPS). The WTO has consistently been an advocate for 'free trade' characterised by lowering trade barriers.

The Washington Consensus

In the late 1970s, increased interest rates intended to curb inflation resulted in crisis conditions for debtor countries, particularly those in Latin America. Debtor countries faced prohibitively high interest rates and bank creditors were unwilling to extend new credit. The political climate of the 1980s furthered the economic isolation of debtor countries with developing economies. Governments of major developed countries such as the United States, United Kingdom and Germany were skeptical of foreign aid and assumed corruption in developing countries' governments.⁴ Ironically, from the mid 1960s to the mid 1980s many commercial banks gave substantial loans to corrupt leaders in Latin America, Asia, and Africa. In the 1980s, later governments of these countries were forced to repay loans, at increased interest rates, that previous leaders had stolen or squandered.

In 1982, threats to default on loan repayment led to a debt crisis in Latin America that threatened the stability of large international creditor banks. In order to preserve international finance systems, creditor governments had no choice but to step in. Through the 1970s, in its role as emergency lender, the IMF had offered loans with conditions that debtor countries devalue their currency and cut government spending in an effort to slow their economies and boost exports to eliminate trade imbalances. During the debt crisis, the monetary and fiscal policy stipulations connected to emergency loans were expanded and formally endorsed as Structural Adjustment Programs (SAPs) by both the IMF and World Bank.

The IMF and World Bank, along with the U.S. Treasury, agreed on a set of structural adjustment policies they believed would promote development and allow developing countries to service their debts. SAP policies were based on the premise that the root of debt crisis was a “short term liquidity problem.”⁵ In response, structural adjustments included spending cuts and revenue generating measures such as downscaling of government, deregulation, rapid liberalisation and privatisation, and cutting social services and food subsidies. The consensus between the IMF, World Bank, and U.S. Treasury regarding the causes and remedies for the Latin American financial crisis was later termed the ‘Washington Consensus’ and laid the foundation for IMF and World Bank policies through the 1980s and 1990s.

Since the 1990s, the Washington Consensus model has received significant criticism. Critics claim that the neoliberal policies endorsed by the Washington Consensus in the 1980s and 1990s depended on a ‘one size fits all’ model that did not take into account individual countries’ economic, political and social situations. Further, Consensus programs are accused of imposing draconian spending cuts on social spending such health and education without significantly reducing debt in developing countries.

Part II

World Bank, IMF and Health Sector Reforms

Introduction to Health Sector Reform

Over the last 25 years, health sector reforms have been instrumental in changing the way health care services are funded and delivered in developing countries. The majority of reforms discussed in this paper occurred in Southeast Asia, Sub-Saharan Africa, Latin America, and the former Communist bloc countries of central and east Asia. While reforms have been undertaken in varying economic, social, and political climates, there are many common practices, namely those linked to the implementation of neoliberal macroeconomic policies supported by the World Bank and IMF, the major engineers of international health sector reform strategies.

This section outlines a loosely chronological series of health sector reforms, beginning with policies included in Structural Adjustment Programs (SAPs), then moving to discuss health sector reforms that were implemented independently of SAPs but with funding and input from the World Bank, the World Health Organization (WHO) and bilateral donors. The section concludes with a discussion of the potential benefits Poverty Reduction Strategy Papers (PRSPs) and the Heavily Indebted Poor Countries Initiative (HIPC) may have on the funding and delivery of health care services in developing countries.

Structural Adjustment Programs

During the 1980s debt crisis, the IMF and the World Bank stepped in to pay developing countries' debts in an effort to maintain the stability of international creditor banks. In turn, developing countries were offered new loans under the condition that their governments adopt policies geared toward stimulating economic growth. These economic policies, packaged as Structural Adjustment Programs (SAPs), were intended to increase revenue, control expenditures and reduce deficits. General adjustment policies included: imposing a ceiling on budget deficits; freezing or reducing government spending; removing subsidies; streamlining bureaucracy; increasing some existing taxes and introducing new taxes; and devaluing currency in order to boost exports.

Following the neoliberal Washington Consensus model of deregulation, liberalisation and privatisation, SAPs required that many public services and utilities, including health care, energy, water, food distribution, transport and education be reduced, sold or commercialised. Specific policies such as reorienting agriculture from food crops to exports, reducing education spending and relaxing labour regulations undermined access to good nutrition, education and stable income, all essential requirements for maintaining good health and utilising health care services.

Privatisation of government services intended to encourage foreign investment, increase export revenue, and decrease spending in the public sector changed employment patterns. Women in the workforce were disproportionately affected by these changes. After privatisation of state enterprises and public utilities in Mexico, over 500,000 state employees lost their jobs.¹ As women generally outnumber men in the public sector as teachers, nurses and public administrators, privatisation-related job losses can impact more women than men. Adjustment policies aimed to boost foreign investment by increasing flexibility and decreasing costs for employers. Relaxed labour regulations reduced job stability, decreased recognition of labour unions, loosened job-safety regulations and eliminated job protections such as those for pregnant women. In Latin America, deregulation allowed for new standards that require female applicants for some manufacturing jobs to prove that they are not pregnant and agree to leave their job if they become pregnant.²

Critics of SAPs link adjustment policies that limited women's and girls' opportunities to earn a living to an increase in commodification of sex. In the absence of viable employment, women engaged in 'sex work' in their home countries or abroad. 'Transactional sex' increases vulnerability to STIs and facilitates the spread of HIV.

In addition to SAP reforms that reduced women's access to health care by limiting employment opportunities, income and independence, adjustment policies specifically targeted to the health care sector effectively reduced the quality and accessibility of health care services.

Under reforms introduced in SAPs, the role of the government in providing universally accessible health care services was significantly reduced. Health sector reforms explicitly aimed to reduce government spending, increase revenues through the introduction of user fees, decentralise health services to regional and local levels, and transfer control and management of hospitals and clinics to the private sector. Implicit in these policies is a reorientation from health care services as a public good to health care services as commodities subject to market forces.

Spending cuts in the health care sector were accepted by developing countries as necessary and inevitable consequences of adjustments intended to spur economic growth and meet World Bank and IMF debt reduction objectives. But prioritisation of debt servicing and subsequent cuts in health care spending resulted in insufficient financial resources for maintaining workable conditions in hospitals and clinics, paying an adequate number of well-trained staff and purchasing medicine and equipment. Further, SAP-recommended devaluation of local currencies, meant to boost the export market, increased the relative price of medicines and medical equipment imported by developing countries. Currency devaluation left developing countries with less buying power at the same time as their health budgets were decreasing. In sum, health services were left with deteriorating facilities, insufficient staff, and minimal medicine and equipment.

In addition to spending controls, reforms included policies geared toward generating revenue. Cost-recovery schemes required users to share the cost of medical services by paying user fees. Institution of user fees deterred people from seeking medical care, reduced lengths of hospital stays, and cut short courses of medicinal treatment. People unable to pay user fees turned to self-medication and home care, often arriving at hospitals only when their illness was already severe.³

SAP reforms in many countries included decentralisation of health service delivery and administration from the national level to regional and local levels. While decentralisation has the potential to benefit health care systems by increasing local input and accountability, responsibilities were often passed to the regional and local level without any corresponding increase in funding or training. Decentralisation cut costs and streamlined bureaucracy at the national level, but left regional and local authorities unequipped to fulfil their new health care responsibilities.

In many cases, the effects of structural adjustments to the health sector disproportionately impacted women. Women, in many cultures, are the traditional caregivers. When access to public health care services is limited by unavailability or prohibitively high user fees, women's care giving responsibilities increase as they look after sick family members in addition to their normal responsibilities at home.

Structural Adjustment in Zimbabwe

Structural adjustment reforms were introduced in Zimbabwe in 1991 and included reductions in public spending on health care. Spending dropped from 3.1 percent of GDP in 1990 to 2.1 percent in 1996. During the same time period, government allocations to the Ministry of Health decreased from 6 percent of total government expenditure to about 4 percent and the per capita budget for health care dropped from US\$22 to US\$11. Between 1990 and 1996, the yearly earning of a health care employee in Zimbabwe dropped from US\$4,321 per year to US\$2,408. User fees were instituted in Zimbabwe in 1991, briefly removed during the drought in 1991-1992, then reinstated and raised in 1994. The unemployed and those earning less than Z\$150 (well below the poverty line of Z\$593 for a family of six in 1991) were exempt from paying user fees. For patients required to pay, the establishment of user fees dramatically increased health care costs, sometimes by up to 1000 percent. It is difficult to tease apart the effects of Structural Adjustment Programs from the general economic and political policies in Zimbabwe under President Robert Mugabe. But, reduced government spending on health care and the introduction of user fees clearly coincided with a decline in quality and accessibility of health care services including reproductive health care. A study conducted in Zimbabwe linked the beginning of user fees in 1991 and 1994 to an

immediate reduction in the number of women seeking prenatal care. Insufficient prenatal care, combined with understaffed, poorly maintained and ill-equipped hospitals is likely to have contributed to the 100 percent increase in the number of women who died during childbirth in hospitals in the capital of Zimbabwe from 1990 to 1993. During the same period, infant- and child- mortality rates increased after steadily decreasing before the introduction of adjustment policies in 1991.⁴

Health Sector Reforms

The World Bank, World Health Organisation and bilateral donor organisations implemented the second generation of health sector reforms in the late 1980s. The reforms were intended to improve efficiency, equity and quality of health care services in economic and political situations made dire by SAPs, public sector inefficiency, declining commodity prices, armed conflict and the HIV and AIDs epidemics. The late 1980s found public health services nearing collapse in many developing countries and utilisation of often unregulated private sector health care services, by those who could afford it, growing.⁵ Early reforms focused on financial reforms, decentralisation, and public-private interactions. Critics of health sector reform claimed that new reforms were simply derivatives of the SAP cost-control and privatisation agenda and voiced concerns that the ‘one size fits all’ nature of health sector reforms failed to take into context particular countries’ medical infrastructure and social and economic barriers to health care.

In the early 1990s there was an increase in health specific funding from multilateral agencies including the World Bank. The World Bank’s lending for health averaged US\$1.5 billion, more than both the WHO and the United Nations Children’s Fund (UNICEF). The increased funding was marked for new non-SAP projects but critics claimed that new World Bank loans would be tied to privatisation and liberalisation of health care services.⁶ The 1993 World Bank Development Report, *Investing in Health*, advocated for a system in which governments provide a basic package of priority health care services and the private sector provides all peripheral services.

The following sections discuss in more detail the range of health sector reforms that were prescribed, independently or as a package, for developing countries including: finance reforms, decentralisation, public-private partnerships, priority setting, service integration and community involvement.

Finance reforms

Health care financing reforms attempt to reduce the amount of money that governments with limited resources spend on providing health care services. Reforms may introduce new financing mechanisms at the service delivery level or reallocate public funds through organisational and structural changes to public health care systems. One goal of reforms is to decrease dependency on tax-based health care funding. Financing mechanisms like user fees, prepayment schemes, social insurance based systems and private sector involvement are intended to replace or subsidise tax-generated funds.

Like user fees introduced during structural adjustments, fee-for-service programs in later health sector reform were intended to generate revenue and use fees to deter users from using unnecessary services. There is no evidence that decreased utilisation rates following the institution of user fees is related to a decline in the frivolous use of services.⁷ Rather, user fees exacerbate inequalities in health care services as they deter people without adequate financial resources from seeking preventative care and finishing courses of

treatment. Exemption programs are intended to prevent fees from discouraging the poorest people from seeking health care services. The exemption system introduced in Ghana allows children under five and people unable to pay to receive free services. Immunisations and pre- and post-natal care are also exempt from charges. But, because of widespread ignorance of the exemption system in rural areas of Ghana, very few people are taking advantage of free services.⁸ When fee exemptions systems are costly to administer and revenue generated through fees stays in the hospital or clinic, there is little incentive to advertise exemption systems and lose profit.⁹

Prepayment schemes, or community funds, rely on voluntary participation. To participate, each household pays a fixed sum of money into the community fund. Participation entitles members to specific health care services and access to medications. Prepayment schemes generally cover often-used, low cost health care services. They are more equitable than fee-for-service programs as they include some measure of risk pooling and cross-subsidising. Both risk pooling and cross-subsidising use group participation to reduce costs for individuals. Community funds include both high-risk members who will use health care services extensively, and low-risk members who might not use any services. Every member is guaranteed health care services and prepayment fees are not linked to the amount of services used. Low-risk members' fees help to subsidise high-risk members' services. While community funds can benefit participants, they have not helped the poorest people in developing countries. Because prepayment schemes are voluntary and require payment, the poorest people in a community often do not or cannot take part. In addition, most community funds have a small membership base and usually require donor or government subsidies to maintain viability.

Social health insurance funds are generally autonomous public funds maintained through a standard payroll deduction from both formally employed persons and their employers. Deductions are based on income level and the contributions of higher-income participants subsidise those of the lower-paid. Social insurance funds make health care services more affordable and offer protection from the financial emergencies often caused by unexpected or serious health problems. Social insurance funds use employer contributions and subsidising to reduce costs for both members and governments. However, participation in social health insurance funds is limited. There is no option for informal workers to take part and in most cases only a small portion of those formally employed, such as government employees, are included.

Decentralisation and Community Participation

Decentralisation of health care service management and funding to the local level and community participation in health care services are embraced in both World Bank health sector reform strategies and the ICPD PoA. The World Bank's World Development Report 1993: *Investing in Health* identified decentralisation of the health care sector as a key health sector reform strategy, and the ICPD PoA advocated decentralisation particularly to encourage community participation and accountability in reproductive health services.

Goals of decentralisation included increased equity, efficiency, quality, and community participation in health care. However, when resource-generating mechanisms are decentralised, inequalities between local communities can be exacerbated. The local administrators of health care services for poorer communities may depend on user fees, which have been proven to deter people from seeking preventative health care, to supplement funds. In order to maintain equity in the dispersion of public funds in

decentralised health systems, local leaders must be fair in the ways in which they allocate funds within their community.

Improved economic efficiency in decentralised health systems depends on local governments who can match health services closely to local needs and preferences. Effective community participation enables local health care administrators to tailor services to meet the community's needs.

The quality of decentralised health care services can also be improved for health care service users by local participation and input. However, improvement depends on the existence of a viable health care system. Further, quality of health care services can be undermined by the upheaval of staff responsibilities and referral chains caused during the transition to decentralised services.

Decentralisation has posed specific challenges for sexual and reproductive health care services. First, local health care services are not always immediately equipped with staff or resources to provide comprehensive integrated sexual and reproductive health services. While the Essential Health Care Package in Zambia included integrated reproductive health care and HIV, AIDS, and STI care and prevention, district level health centres could not implement the full package because of limited resources.¹⁰ Limited resources and reorganisation after decentralisation has been related to problems in the procurement and dispersal of medical equipment and supplies which reduces availability of contraceptives and essential drugs for sexual and reproductive health needs. Finally, the success of decentralisation for SRH depends on local officials having correct information about SRH and prioritising SRH services. Effective community participation provides the framework for SRH services that are responsible to the sexual and reproductive needs of the population. In order for the decentralisation-community involvement system to function, members of the community must have the space to express their SRH needs to local leaders, advocate for their SRH care, and hold leaders accountable. These needs can only be met in communities with a degree of democracy in decision-making and respect for women's health needs.

For many of the reasons listed above, the ICPD-PoA calls for women to be involved in all aspects of SRH policy decisions and implementation. HSR strategies vary in their ability to effectively pursue community involvement and accountability in SRH. In the worst cases, community involvement is sought at the level of involvement through cost sharing and user fees. Beyond user fees, HSR-implemented community involvement in SRH has focused more in involvement at the management than at the policy level. Community involvement planned through HSR has improved some family planning, maternal health, and HIV and AIDS services, but has not been particularly effective in contested issues like abortion and violence against women. There are positive cases in which communities that demanded involvement in SRH, independent of HSR, have made gains in representing minority women and implementing controversial legislation.¹¹

Public-Private Interaction

Public-private interactions follow a number of diverse models. 'Social marketing' and 'social franchise' programs apply market tools, concepts and resources to deliver health products and services, respectively. Social marketing programs have been widely used to integrate brand advertising and reproductive education into subsidised lower-cost contraceptive distribution. Governments or bilateral donors cover initial social marketing costs and some programs earn enough through sales to become self-

supporting. Cost-recovery can be unmanageable for social marketing programs that keep contraceptive prices low enough to maintain access for low-income populations. These programs depend on continued government or donor funding. Thailand's social marketing program utilised community volunteers to distribute low cost contraceptives in combination with behaviour change education at the community level. The program is seen as an integral part of Thailand's high levels of condom and oral pill use.¹²

Social franchise programs create networks of private health practitioners who offer a standard set of high quality services and clearly determined prices under a shared brand name. Social franchising can benefit SRH services by improving access to services by increasing the number of providers, by assuring the quality provided by the brand name, by offering a wide range of services through multiple complementary franchises, and by providing institutional stability.

In another variety of public-private interaction, the public sector contracts private health care providers in order to use private sector resources, divert clientele from the sometimes under-resourced public sector to the private sector, or expand the scope of SRH services. Recently, programs in which public funds are used to expand private sector services have gained in popularity. The 'Midwives Loan Fund,' set up in Indonesia in 1997, made loans available to experienced midwives to expand their private clinics for provision of delivery care as well as contraceptive services. Assessments indicated that midwives who received loans were reaching new family planning clients, including some who previously used the private sector.¹³

Public-private interactions such as social marketing, social franchising and contracted private services can be useful in a complementary role. Private sector resources can benefit SRH services for those with the ability to pay and reduce the burden on under-resourced public health care services. But problems arise when public-private interactions are used to substitute public services. When social franchises are the only alternative to private SRH care, people's choice is essentially reduced to either paying for services, or forgoing them. Further, to maintain viable SRH services for the poorest people in a population, it is important the donor funding is not channelled to support public-private interaction that only serves those who can pay.

Integration

Both the ICPD PoA and World Bank and IMF health sector reforms advocate integration as a tool for increased quality and efficiency in health care. Integration in the health sector can occur at the planning, budgeting and managing levels or through multipurpose clinics and multi-skilled staff. Integration measures outlined in the World Bank's 1993 World Development Report generally fall into the former categories and aim to increase efficiency of health sector management, administration and planning. The ICPD PoA advocates for universal access to reproductive health care, integrated with and accessible through the primary health care system, by 2015. Further, the PoA advocates integrating sexual and reproductive health services, family planning and HIV and STI detection, prevention, and treatment services.

There are some good models of health care service integration. In Latin America, including gender violence screening in reproductive health services increased detection rates.¹⁴ A 1995 study in rural Tanzania found that syndromic management of STIs at the primary health care level reduced HIV incidence by 40%. Syndromic management of STIs involves treating all of the common infections that may be causing a patient's

symptoms and is used particularly in cases when resources don't allow for the lab equipment necessary to identify particular STIs. Because STIs increase the risk of contracting HIV, effective management of STIs at the primary health care level helped to reduce incidences of HIV. By confirming these links between STIs and HIV transmission and providing working model of an integrated approach at the primary health care level, the trial spurred the movement toward integration.¹⁵

Since the mid-1990s, health care service integration has been met with many challenges. While sexual and reproductive health care integration into primary health care may increase access to services, there is no conclusive evidence that integrated service delivery is economically efficient. Additional equipment and staff training requirements necessitate increased funding. In situations where cost saving is paramount, integration programs can leave health care providers with less time and more diverse workloads. In order to meet ICPD PoA goals, integration policies must include provisions for the increased funding and training required to make integrated SRH and PHC services viable.

Priority Setting

The World Bank's 1993 World Development Report, *Investing In Health*, introduced global burden of disease analysis and the associated priority setting methodologies for health sector reform. The aim of priority setting is to determine which health care services use developing countries' scarce resources most efficiently.

Priority setting methodology determines burden of disease in terms of the Disability Adjusted Life Year (DALY). One DALY is equivalent to one year of healthy life lost due to a disability or premature mortality. The cost effectiveness of a treatment is determined by dividing the number of DALYs averted by treatment by the treatment cost. High priority interventions address conditions for which both the burden of disease and the cost effectiveness is high. Priority interventions are included in a country's essential package of services, the list of services to be provided by the government. Services outside the package do not receive government funds and are usually provided by the private sector. The essential services provided by the government vary based on the resources available in a particular country.

The development of the DALY and priority-setting methodology was informed by a perceived need to use epidemiological evidence rather than advocacy to create an objective measure of both the mortality and morbidity attributable to different diseases. The focus on epidemiology over advocacy is fundamentally different from the ICPD PoA's rights-based approach to reproductive health care, population and development. The DALY value and priority level assigned to a particular disease is determined mathematically and essential services are assigned based on resource availability, rather than need. Without advocacy, these methods fail to take into account individuals' rights to health care services, including reproductive health care.

Critics claim that DALYs fail to fully account for contextual differences that exacerbate burden of disease for specific populations, particularly women and those living in poverty. For example, age weighting is used in the determination of DALYs. Deaths or disabilities occurring in old age or childhood accrue fewer DALYs than those occurring during the middle years, generally the most economically productive period of one's life. Age weighting fails to recognise that work and caregiving patterns differ in different cultures and economies. In communities where young girls and elderly women are key

caregivers and food preparers, the burden of disease caused by their illness could be equal to that of middle-aged men and women.

Weighting is also used to determine the severity of an illness in the development of DALYs. The severity weight is intended to represent both the functional loss and the social impact of a disease in the 'average social milieu.' DALYs are relevant measures only if poor women experience a similar burden of disease to those in the 'average social milieu.' That is not the case. For example, menstrual disorders may not be considered severe for the average woman, but poor women in developing countries who lack adequate nourishment, clean water, basic sanitary products and cultural support for privacy could be severely affected by heavy menstrual periods.¹⁶ The DALY weighting system fails to address the ways in which poverty exacerbates the burden of disease.

In some cases there is a fundamental discrepancy between the sexual and reproductive health services deemed 'essential,' and the standards of reproductive health care defined by the ICPD PoA. The PoA outlines a model of reproductive health care that includes education, counselling and services throughout a woman's life cycle related to family planning, prenatal care, safe delivery, post natal care, infant care and breast-feeding, treatment of reproductive tract infections and STIs, HIV and AIDS, breast cancer and cancers of the reproductive system. The WHO and World Bank list of essential reproductive health interventions includes: prenatal, delivery, and post-partum care, emergency obstetric care, family planning, treatment of STIs and HIV prevention. The WHO and World Bank package excludes uterine prolapse, vaginal fistulae, menstrual disorders and ovarian and uterine cancers. Priority setting in most countries is guided by this package, but some countries offer an even narrower range of essential reproductive health services.¹⁷

Poverty Reduction Strategy Papers

Poverty Reduction Strategy Papers (PRSPs), the contemporary successors to World Bank and IMF Structural Adjustment Programs, are national planning frameworks for low-income countries. To access concessional assistance from the World Bank or IMF, or participate in the Heavily Indebted Poor Countries Initiative, countries are required to develop a PRSP. The World Bank defines PRSPs as country-owned strategies intended to look beyond macroeconomic stabilisation to address the multidimensional nature of poverty and formulate long-term solutions for poverty reduction. In this capacity, PRSPs offer a much greater potential than SAPs to improve health care services in developing countries. Ideally, PRSPs would address the relationship between poverty and poor health and include recommendations based on the premise that improving health reduces poverty.

PRSPs may be limited by their role as funding applications to the World Bank and IMF. Some critics have dismissed PRSPs as neoliberal structural adjustment policies under a new title. While the World Bank claims that strategies presented in PRSPs are country-owned and developed to meet individual countries' needs, some civil society organisations involved in PRSP planning described their role as that of an "alibi, rather than being recognised as a true partner in the process."¹⁸

A 2004 WHO review looked for evidence of effective pro-poor health policies in 21 PRSPs. Pro-poor health policies reflect links between poverty and health by prioritising

the health needs of the poor, health interventions aimed to reduce poverty, and monitoring mechanisms to gauge progress including steps toward meeting Millennium Development Goals. In particular, the WHO looked at inclusion of maternal and child health strategies in PRSPs.

The analysis of barriers to health care services for the poor in the PRSPs include lack of staff, management and infrastructure problems, financial barriers such as fee-for-service policies and a shortage of medicine and other resources. While most PRSPs imply that a lack of skilled birth attendants contributes to increased maternal mortality rates and higher chances of complications at birth, few PRSPs discuss particular barriers that prevent poor women from accessing reproductive care, such as distance, cost, and cultural practices.¹⁹

PRSPs are limited in the power of their recommendations. According to the WHO report, while PRSPs identify the problems poor people face when seeking health care services, they do not systematically identify the health issues that contribute to poverty and propose solutions and means of monitoring progress. Further, the report states that the budgets presented in PRSPs will not result in large increases in resources available for health.²⁰ While the country-owned poverty reduction framework of PRSPs gives them the potential be the foundation for strategies to meet ICPD PoA and MDG objectives, they falter as they do not pursue a well-defined human rights based approach to the dual goals of poverty reduction and health care service improvement.

Heavily Indebted Poor Countries

The World Bank and IMF began the Heavily Indebted Poor Countries (HIPC) initiative in the late 1990s to address concerns that the debt burden in developing countries was hindering poverty reduction efforts. HIPC aims to reduce debt in developing countries to a sustainable level (150% of exports or in some cases 250% of fiscal revenues) by calling for multilateral, bilateral, and commercial creditors to voluntarily cancel a portion of each HIPC country's debt. Approved HIPC countries are given provisional debt relief until they reach agreed-upon 'completion point triggers' which include at least one year of implementation of a poverty reduction strategy as well as progress in social areas such as health and education, improved governance, or decreased corruption. Upon successfully reaching their completion points, debt relief becomes permanent.

Tax revenue made available through HIPC debt relief programs could potentially be reallocated to fund health care services. But there is little current information regarding how much health care services' resources will actually benefit from the HIPC initiative.

Part III

World Trade Organisation Agreements: The General Agreement on Trade in Services (GATS) and Trade Related Aspects of Intellectual Property Rights (TRIPs)

Introduction

The 1995 Uruguay Round of World Trade Organisation (WTO) negotiations brought regulation of both international trade in services and intellectual property rights under the auspices of the WTO. The first part of this section discusses the General Agreement on Trade in Services and the ways in which the agreement impacts the provision of health care services, with particular regard to its emphasis on privatisation and liberalisation of services. The second part of the section outlines the Trade Related Aspects of Intellectual Property Rights (TRIPs), focussing on how the protection of intellectual property effects availability and affordability of patented pharmaceuticals.

The General Agreement on Trade in Services

The General Agreement on Trade and Services (GATS) is the first and only multi-lateral agreement on the regulation of services. Before 1995, international trade regulations only applied to trade in 'things' such as agricultural products, textiles or computers. GATS regulations apply to the international buying and selling of any service, including but not limited to banking, telecommunication, and medical services. A variety of trade relationships are included within GATS: those in which only a service crosses the border, such as pharmaceuticals purchased over the internet; the establishment of foreign owned enterprises such as hospitals; and the movement of people across borders to buy or sell services. According to the WTO, the goal of GATS is to expand and liberalise trade in services as a means to economic growth for all trading partners. Critics argue that GATS is used as a tool by corporations in developed countries to open or privatise new markets in developing countries.

GATS is unique among WTO agreements as it includes both mandatory and voluntary commitments. All WTO members must comply with unconditional obligations while each member can choose to what degree they wish to undertake conditional obligations.

Unconditional Obligations

Under GATS, most favoured nation treatment (MFN) obligations apply to all WTO members for all services, regardless of whether or not a member country has voluntarily opened the particular service sector to international competition. MFN prohibits any form of nationality-based discrimination between trading partners; trade conditions offered to one country (even a non-WTO member) cannot be denied to any other member country. For example, if a government gives a tax break or special regulatory treatment to any one foreign health care service, it must extend the same treatment "immediately and unconditionally to every interested company from every WTO country."¹ Conversely, MFN requires that a WTO member who wishes to prohibit trade in any health sub-sector must operate the prohibition vis-à-vis all of its trading partners. Exemptions to MFN treatment were available to WTO members at the time GATS came into force, or when newer members joined the WTO. Initial exemptions are valid for only ten years, and both supporters and opponents of GATS agree that later exemptions are difficult to negotiate.²

Transparency requirements also apply to all WTO members and oblige governments to make relevant laws and regulations governing service sectors accessible.

Conditional Obligations

Each WTO member can engineer the combination of voluntary commitments they wish to undertake. Member countries choose which service sectors they wish to open to foreign competition, which types of service delivery within those service sectors they open to foreign competition and to what degree they will provide or limit market access and national treatment. These voluntary commitments are formally listed in documents called schedules of specific commitments. Member countries are only required to comply with GATS conditional obligations that they have listed in their schedule of specific commitments.

GATS classifies services into twelve core sectors that are further divided into 160 sub-sectors. The health-related and social services core sector includes, among others: medical and dental services; services provided by midwives, nurses, physiotherapists and paramedical personnel; hospital services; and other human health services such as ambulance services and residential health facility services.

In their schedules of specific commitments, WTO members can distinguish between four modes, or types of service delivery: Mode 1, cross border supply, occurs when only the service (rather than the service provider) crosses a border and includes purchasing medicine or medical advice over the internet; Mode 2, consumption abroad, occurs when consumers travel abroad to purchase services, such as medical treatment, outside their own one country; Mode 3, commercial presence, refers to locally-established subsidiaries of foreign companies like foreign owned hospitals and clinics; Mode 4, the presence of natural persons, includes the temporary admittance of foreign nationals to provide services, such as health care workers or hospital staff.

For each service sector and mode of supply voluntarily opened to international competition, countries can specify their degree of commitment to market access and national treatment. Full market access guarantees that a government will not enforce quota restrictions such as limits on the number of service suppliers, the value of service transactions or assets, or the quantity of output. Market access commitments apply equally to national and foreign service providers. Full national treatment ensures that no regulations will be imposed on competition to the detriment of foreign service suppliers. Prohibited conditions include restrictions on non-resident ownership of services or preferential tax treatment for locals.

Case Study: Cambodia's Schedule of Specific Commitments

Hospital services are the only health-related and social service sub-sector Cambodia has opened to foreign competition. Cambodia's commitments only apply to private hospitals and clinics, which exempts policies regarding the country's public hospitals from market access requirements. Both market access and national treatment are guaranteed without any limitations for Mode 1 (cross border supply) and Mode 2 (consumption abroad). Regarding Mode 3 (commercial presence), market access is guaranteed, with the limitation that one director for technical matters must be Cambodian and national treatment is assured without limitation. For Mode 4 (presence of natural persons) Cambodia's schedule of specific commitments includes horizontal limitations, which apply across all service sectors, for the qualifications and duration of stay of foreign nationals. In addition to the market access and national treatment commitments

Cambodia lists in its schedule of specific commitments, laws regarding trade in the country must conform to domestic regulation requirements for all scheduled sectors and uphold GATS mandatory MFN and transparency requirements.

Exemptions

GATS critics claim that exemptions from scheduled commitments are too difficult to negotiate. According to the WTO, the purpose of maintaining scheduled market access and national treatment commitments is to encourage trade by ensuring stability and predictability of trading conditions. Opponents claim that GATS serves to entrench liberalisation without considering economic or social conditions that may warrant late limitations or exemptions to voluntary commitments. While the WTO emphasises that “commitments are not a straitjacket,”⁴ after market access or national treatment is initially granted, countries who wish to renegotiate new limitations must compensate all trading partners for future lost business, “making reversals of even the most disastrous privatisations or deregulations excruciatingly difficult.”⁵

An exemption clause under GATS Article XIV does allow WTO members to depart from any GATS obligation, including scheduled market access and national treatment, if it is necessary to “protect human, animal or plant life or health, subject to the proviso that there be no arbitrary or unjustified discrimination or disguised restriction on trade.”⁶ GATS opponents claim that WTO dispute panels have generally interpreted exemptions in favour of trade and ruled against protection measures. The dispute panel’s precedent indicates that, despite the exemption in Article XIV, GATS has the potential to challenge government regulations intended to protect health if they are seen to negatively affect conditions of competition or restrict trade.⁷

Domestic Regulation

The WTO assumes an important link between the domestic regulatory environment and continued trade liberalisation. GATS Article VI.4 aims to prevent domestic regulations such as qualification requirements and procedures and technical standards and licensing requirements from constituting unnecessary barriers to trade in sectors WTO members have opened to competition.⁸ In the context of health services, domestic regulations could include licensing of hospitals and health professionals. ‘Technical standards’ could potentially include a wide range of health-related services under government control including the funding and delivery of services such as insurance reimbursement schemes.⁹ While Article VI.4 has the potential to affect domestic regulation of health service provision, the rules on regulation are still rudimentary and open to further interpretation.¹⁰ The literature presents differing views on how GATS-guided shaping of domestic regulation will affect health care.

Proponents of GATS claim that the agreement makes a clear distinction between domestic regulations and measures subject to trade liberalisation. The WTO states that governments remain free to pursue domestic policy to ensure that their population has “equitable access, regardless of income or location, to a given service” even in sectors where they have undertaken full commitments on market access and national treatment.¹¹ This explanation indicates that domestic policies that aim to provide access to health care services would not be infringed upon by Article VI.4.

Opponents of GATS approach Article VI.4 with much more uncertainty. According to the WTO, ineffective and inconsistent regulation can hinder the benefits of liberalisation, and Article VI.4 in the GATS agreement states that domestic regulation should not be

more burdensome than necessary. The Working Party on Domestic Regulation (a subgroup of the Council for Trade in Services, the body within the WTO that oversees GATS) has considered clarifying the definition of “least burdensome” in Article VI.4 to mean “pro-competitive.” The EU includes cross-subsidising by monopoly providers of services in its definition of “anti-competitive practices.” Cross-subsidising and other non-market mechanisms such as risk pooling and social insurance funds are key elements of public health insurance plans.¹ In the case that the WTO defines “least burdensome” as “pro-competitive,” these practices could be challenged as anti-competitive under Article VI.4 by WTO members.¹²

Public Services

Theoretically, GATS obligations do not apply to public services. Article I:3 exempts “services supplied in the exercise of governmental authority” from MFN, market access, national treatment, and domestic regulation requirements. To qualify for exemption, Article I:3C specifies that government services must be “supplied neither on a commercial basis, nor in competition with one or more service suppliers.”¹³ Typical exempted public services include police, fire protection, monetary policy operations, mandatory social security, and tax and customs administration. Exemptions guaranteed by Article I:3 are equally relevant to treatment in public hospitals which meet exemption requirements. Public services exempt by Article I:3 cannot draw requests for liberalisation, nor can they be challenged under MFN or domestic regulation requirements. Supporters and opponents of GATS offer different interpretations of the implications of this exemption

GATS makes it clear that if public services are commercialised or privatised, they lose exemption status and immediately fall under the Agreement’s MFN and transparency requirements. Opponents of GATS question how clearly and fairly Article I:3’s exemption criteria apply to public services. While GATS is not an independent agent of privatisation, to fully understand the consequences of Article I.3, it is important to consider it in context with other mechanisms used to liberalise and privatise services such as World Bank and IMF Structural Adjustment programs, health sector reforms, and bilateral agreements.¹⁴

Article 1:3’s exemption criteria, that public services must neither be supplied commercially nor in competition with any other provider, is relatively narrow. SAPs, health sector reforms, bilateral agreements and governments’ decisions to privatise have undermined the possibility of health care services meeting the criteria. Public-private partnerships in health sector reforms blur the line between public and private services. The UK has introduced programs in which hospital buildings are privately owned, while provision of hospital services remains public.¹⁵ If a government contracts out any part of its public services, such as cleaning or catering, a WTO panel may find that it no longer meets the criteria of a government service. Further, many public services, like hospital care, are provided by both government and private operators, presumably in competition with one another, and thus do not qualify for the exemption.¹⁶ Public health care services

¹Risk pooling and cross-subsidising in health insurance plans use group participation to reduce costs for individuals or governments. Insurance plans ‘pool risk’ by including high-risk members who might use health care services extensively, and low-risk members who might not use any services. Because of changing life stage or emergency, a low risk member may become a high-risk member. Every member is guaranteed health care services and membership fees, if they exist, are not linked to the amount of services used. Cross-subsidising allows low-risk members’ fees to help subsidise high-risk members’ services.

are not required to privatise or commercialise if they lose exemption status.¹⁷ Because non-exempt services must adhere to MFN treatment, if one international trading partner is allowed to provide health care services, other international partners must be given the same rights. Non-exempt government-provided services are less protected from liberalisation.

Legislation in the Canadian province of Alberta allows private for-profit facilities to offer overnight hospital care and provides the facilities with some public funding. This legislation undermines the Canadian health care system's status as a public service under GATS article I.3 as it introduces competition and for-profit commercialisation of hospital care.¹⁸ The Alberta legislation could also trigger the application of North American Free Trade Agreement (NAFTA) obligations which would prevent the Canadian government from intervening to prevent the liberalisation of health care services in other provinces.¹⁹

Patterns of Commitments

The implications of GATS for health care are disputed. In addition, there is little literature regarding the ways in which GATS may affect reproductive health care in particular. The lack of information may be explained in part by the relatively small number of countries that include the health care sector in their service schedule. During the Uruguay round of negotiations, less than 40% of the 150 WTO member states made health sector commitments.²⁰

Health commitments that are made by developing and least developed countries under mode 3 (commercial presence) may be intended to compensate for domestic shortages of physical and human capital. Commercial presence commitments, in the best scenario, promote improvements in health care services through foreign investment as well as an influx of supplies, skills, and expertise.²¹ Even considering these commitments, health care is one of the least committed sectors in the GATS agreement.

One explanation for low levels of commitments in the health care sector is the existence of government health care monopolies which offer services for free or significantly below cost in countries where private health care services are either prohibited or commercially unattractive.²² These government policies and practices, which discourage private provision of health care services, can reduce the perceived need for mode 3 (commercial presence) commitments. Opponents of liberalisation support the protection of government-provided health care services from privatisation and competition for resources. Supporters of increased health care sector liberalisation note examples where private providers do exist and survive economically alongside public health care services and conclude that public and private providers are not competing directly and may be providing services with different waiting periods, quality of equipment, and types of treatment.²³ The argument that public and private health care providers supply different services highlights one fundamental problem discussed by opponents of privatisation. Private for-profit health care services can lead to a two-tiered medical system, where those who can afford private care have shorter waiting periods, better equipment, and a wider range of treatments available than those who depend on the under-funded public system.

A second possible reason for the shallow level of initial health sector commitments is the lack of vocal export interests. During the Uruguay Round negotiations, requests for liberalisation may have been weak in the health sector as no WTO members took on the

role of ‘pacesetters’, as the USA and EU did in telecommunications negotiations.²⁴ According to the WTO, the importance of the Uruguay Round of service trade negotiations “lay less in its improving actual market conditions, but in creating a completely new system of rules and disciplines for future trade liberalisation.”²⁵

Progressive Liberalisation and GATS 2000

GATS is the first WTO agreement to include a provision guaranteeing progressive liberalisation. Article XIX:1 commits member countries to negotiations aimed to further liberalise trade in services and provided for a new round of service negotiations to begin no later than 2000. GATS 2000 negotiations were intended to “conclude an ambitious package of additional liberalisation by developing as well as developed countries.”²⁶ The US, EU, Japan and Canada were pushing, in particular, to increase the service sectors and modes of supply scheduled by WTO members; to reclassify services in order to side-step some countries’ reluctance to open them up to foreign competition; to add new rules and restrictions which would apply to all WTO members’ service sectors regardless of whether they have been voluntarily scheduled (following the model of unconditional MFN requirements); and to place new constraints on domestic regulation. Had these goals been achieved, they would have vastly expanded the scope of GATS, in some cases reducing the voluntary nature of liberalisation.²⁷

There is some debate surrounding the fairness and transparency of GATS 2000 negotiations. Before the launch of GATS 2000 talks, a coalition of developing countries requested an assessment of previous GATS service trade liberalisation; a global campaign of civil society groups called for a moratorium on GATS 2000 negotiations until the assessment was completed.²⁸ The WTO, despite acknowledging the lack of available data for reviewing trade in services, continued with negotiations to extend the scope of GATS.²⁹ Further, although GATS mandates transparency, there are claims that GATS 2000 negotiations occurred privately between government representatives and corporate lobbyists outside the realm of public discussion and debate.

Despite ambitious goals, GATS 2000 negotiations failed to result in any new commercial opportunities for service suppliers.³⁰ While GATS 2000 did not lead to any substantial increases in health sector commitments, the commitment to further liberalisation of services guaranteed by Article XIX.1 and the influence of economically powerful countries in the WTO makes further liberalisation of health care services a likely possibility. The Hong Kong Ministerial Declaration of December 2005 is meant to re-energise efforts toward service liberalisation. The Hong Kong declaration offers a measure of hope for reasonable furthering of liberalisation as it includes a statement which exempts least developed countries (LDCs) from the expectation to undertake new commitments.

Concerns

Concerns over the implication of GATS for access to health care services are generally based on broader concerns around the WTO’s neoliberal policies which encourage liberalisation and privatisation of public services. GATS is not an independent agent of privatisation in the health care sector; as of yet it has not been instrumental in opening health care markets to foreign competition.³¹ However, GATS does have both real and potential effects on affordable access to quality health care services. While GATS does not directly privatise, the commitment in Article XIX.3 to continued liberalisation as well

as the difficulty of renegotiating MFN, national treatment and market access limitations gives GATS the power to entrench current levels of privatisation and encourage further liberalisation.

Advocates of liberalisation and privatisation claim that competition and profit motive encourage improved efficiency and provision of high quality care. While competition and profit motive can benefit health care services, the particular services advocated for in the ICPD PoA generate little profit. The ICPD promotes prevention, education and adolescent services among its SRH goals. These lower cost services are not always prioritised by the private health sector. The ICPD PoA aims to provide universal access to SRH services within the primary health care system by 2015. ‘Universal access’ includes access for populations in least developed countries. Provision of affordable services in these countries cannot generate substantial profit while remaining accessible. These cases emphasise the reasons health care services must be provided as a human right and public good, rather than a market good sold for profit.

GATS guidelines, in some cases, are in direct opposition to government efforts to make health care services more affordable and accessible through subsidies and economic needs tests used to ensure that services are provided in locations where they are in demand, rather than where the market is already saturated.

U.S. law currently requires pharmaceutical companies to offer medicines at reduced rates to Veterans Administration facilities and for hospitalised Medicare recipients.² The Medicare Disproportionate Share Hospital (DHS) program provides higher reimbursement rates for publicly funded hospitals which serve a large percentage of low-income and uninsured patients and Medicare beneficiaries. While the U.S. limits federal or state reimbursement for medical services received outside the U.S under mode 2 (consumption abroad) national treatment restrictions, there are no limitations listed that restrict enforced government and pharmaceutical subsidies to public facilities.³² As the United States includes hospitals services in its schedule of specific commitments, GATS national treatment commitments require the US government to offer the same public funds, benefits, and reimbursement rates to private-sector, for-profit hospitals. If challenged, GATS could force the U.S government to choose between offering many more reimbursements and continuing the program at a much higher cost, or ending the program, which might financially debilitate public hospitals, effectively reducing public health care and increasing private health care services.³³

South Africa’s 2004 National Health Act (NHA) aims to make the health care system more equitable in an environment where the social and economic costs of HIV have worsened structural problems inherited from the apartheid era.³⁴ The “main policy instrument” used by the NHA to repair inequalities and ensure uniform access to health care services is the “certificate of need” requirement.³⁵ The NHA’s certificate of need requirement is one model of economic needs testing, a type of analysis that determines the needs of particular market. In South Africa, economic needs testing is used to ensure that health care resources are made available to poor and rural populations, rather than being directed to rich and urban neighbourhoods that are already saturated with health care service providers. Certificates of need redistribute health care resource based on public health needs, rather than market forces. Public, private for-profit and private not-for-profit inpatient and outpatient medical establishments in South Africa cannot operate

² Medicare is the United States’ public health insurance plan

without a certificate of need. Public health authorities can approve or deny certificates based on communities' needs and attach stipulations requiring health establishments to train community health professionals or provide services geared for low-income communities.³⁶

GATS market access requirements, which apply to both international and domestic service providers, stipulate that member countries cannot apply "economic needs testing to the approval of new or the expansion of existing health establishments, without having previously listed needs testing as a market access limitation in their schedule of specific commitments."³⁷ The certificate of need required by the NHA can be considered a barrier to market access and is clearly prohibited by GATS. South Africa made their GATS market access commitments in 1994, before the NHA passed in 2004. They did not schedule economic needs testing or mandatory certificates of need as a market access limitation. The economic needs testing employed by the NHA to improve equality in health care services puts South Africa in non-compliance with the GATS agreement.

The South African government has several options for dealing with the policy discrepancies between the NHA and GATS. One possibility is to continue implementing NHA policies and wait to see if any conflicts arise. The WTO, as a governing body, does not directly challenge member governments' policies. Challenges are raised by one WTO member government against another and settled by the WTO dispute settlement system. For diplomatic reasons, most governments may hesitate to bring South Africa's economic needs testing before the WTO, fearing the international controversy that would likely result. Foreign governments that do object to the required certificate of need may be reluctant to bring attention to their own GATS-inconsistent health policies. South Africa could also withdraw from its GATS health service commitments. As discussed earlier, renegotiating GATS commitments is a difficult and costly procedure. South Africa would be required to negotiate increased GATS coverage in other sectors to compensate member governments for their service suppliers' lost market access. Some GATS critics see South Africa's situation as an opportunity for a WTO member government to make a strong statement about the potential harm GATS' inflexibility can bring to public health services.

While WTO members have undertaken a relatively low number of commitments in the health sector, commitments in other sectors have the potential to affect access to health care services as well as basic necessities for good health. Financial service companies, including health insurance providers, have been the most organised supporters of GATS. GATS liberalisation of health insurance and data processing in hospitals could undermine the administrative and financial requirements for quality and efficient health care services. At a more basic level GATS has the potential to affect the root causes of health problems. Regulations that govern sale of tobacco and alcohol and protect workers' safety could be seen as anti-competitive trade barriers and be challenged under GATS. Further, in an effort to facilitate the privatisation of water, the EU has attempted to have water services classified under GATS and encourage countries to open up their water supply services to competition. Privatisation of water and sewage typically leads to increased prices and in turn, reduced access to clean water and sanitation for drinking, cooking and agriculture.³⁸

Trade Related Aspects of Intellectual Property Rights (TRIPs)

The trade related aspects of intellectual property rights (TRIPs) agreement came into force during the 1995 Uruguay Round of WTO negotiations and established minimum

standards for protection of intellectual property rights. TRIPs regulates and enforces protection of copyrights, patents and trademarks. Pharmaceutical patent regulations are particularly relevant to issues of accessible and affordable HIV and AIDS treatment. The TRIPs agreement requires WTO members to make patents available for all inventions of products and processes. Patents must guarantee the owner the exclusive rights to make, use and sell their product or process for a period of no less than 20 years.³⁹

According to the WTO, an orderly and predictable international system for protecting and enforcing intellectual property rights facilitates technological innovation and dissemination.⁴⁰ In the WTO model, exclusive patent rights, and the associated profits, encourage development of new and improved products and technologies which will benefit general social and economic welfare. Critics of TRIPs argue that the current patent protection system has not improved the availability of important pharmaceuticals, like HIV and AIDS treatments and drugs for tropical diseases, for poor populations in developing and least developed countries. When patent holders have exclusive rights to produce pharmaceuticals, they are effectively given a monopoly. Without competition from generic producers, there is no pressure for pharmaceutical companies to lower drug prices.

TRIPs is based on the assumption that the possibility of profits derived from exclusive patents will encourage innovation. But the TRIPs agreement does not include any mechanisms to ensure that innovation in pharmaceutical development has global benefits. Nearly all drug research and development occurs in the private sector and is driven by potential profit (profit guaranteed by TRIPs). Only 1 percent of the 1,400 new medicines developed in the last 25 years is used for tropical diseases. These diseases kill tens of thousands of people each year. Because drugs for tropical diseases are needed most in the developing world, they do not present a profitable market for pharmaceutical companies and have not been a priority. Further, patents do not always encourage innovation in development of drugs. Fixed-dose or 'three-in-one' pills are important to AIDS treatment but their development is difficult as the patents for the individual pharmaceutical components of the 'three-in-one' pill are held by different companies.⁴¹

When the TRIPs agreement came into force in 1995, developing and least developed countries were allowed an extended transition time to fully adopt TRIPs patent regulations into their national laws. Until 2005 when the TRIPs agreement was fully implemented, some countries, including Brazil, Thailand and India, did not grant patents. These countries continued to allow production of low-price generic pharmaceuticals for both domestic use and export. Before 2005, India was the primary exporter of affordable antiretroviral (ARVs) drugs important for the treatment of HIV and AIDS. HIV and AIDS treatment programs in developing countries that depended on imported ARVs were left without a source of affordable pharmaceuticals.

Doha Declaration

The 2001 Doha Declaration on the TRIPs agreement and Public Health recognised developing countries' concerns about the high cost of patented medicines. According to the declaration, "the [TRIPs] agreement can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all."⁴² The Doha declaration reaffirmed that developing countries should make use of all the flexibilities in the TRIPs agreement to promote public health, and extended the transition period for least developed members to enforce patent protection for pharmaceutical products until January 2016.

Flexibilities in the TRIPs Agreement

Parallel importing allows governments to import, without permission of the patent holder, a patented product sold at lower prices in another country. TRIPs does not address parallel importation; individual members can allow parallel imports as long as they do not discriminate on the grounds of the nationality of the patent holder (most favored nation) and treat imported products the same as domestically produced products (national treatment). Because the same drug may be sold at significantly different prices in different countries, parallel importing is an important tool for providing affordable pharmaceuticals.

The 1995 TRIPs agreement permitted member countries to issue mandatory or compulsory licenses, which allow companies to legally produce generic versions of patented products without the consent of the patent holder, in situations of national emergency or for public non-commercial use. The availability of generic pharmaceuticals, which are generally more affordable than their brand-name counterparts, encourages price competition and is essential to making HIV and AIDS treatment accessible in developing countries. After the Zimbabwe government declared the HIV and AIDS epidemics a national emergency in 2002, the government issued compulsory licenses to local companies to either import or produce generic ARVs. The price of the ARV Zerit was reduced from US\$400 in 2001 to US\$30 in 2002.⁴³

The 1995 TRIPs agreement stipulated that products produced under mandatory licenses could only be used domestically.⁴⁴ Most of the developing countries that depend on generic pharmaceuticals, especially countries in Africa, do not have the facilities or resources to produce medicines. These countries depend on imported generics. Following the commitment to public health issued in the Doha declaration, the WTO's 2003 'August 30th decision' waived the domestic use stipulation and authorised members to issue compulsory licenses for the production of pharmaceutical products for export to eligible importing members.⁴⁵

While the WTO's decision to allow export of pharmaceuticals produced under compulsory licenses is an important step forward, critics claim that the complexity of the 'August 30th decision' limits its ability to maintain a supply of low cost generic pharmaceuticals in developing countries. Compulsory licenses are granted on a drug-by-drug, country-by-country and case-by-case decision making process. Further, the compulsory license can only be used for the scope and duration of time authorised by the government. This system divides the pharmaceutical market in a way that cannot be expected to attract interest from potential generic pharmaceutical producers looking for a viable export market.⁴⁶

In order to fully take advantage of the flexibilities endorsed by the Doha declaration and ensure the availability of affordable pharmaceuticals, developing countries need to incorporate TRIPs flexibilities into their national laws and policies. For example, small countries, especially those in south and east Africa with a shared need for imported generic ARV's, could develop a regional protocol for working together to establish a trade relationship with a country that exports generic medicines.⁴⁷ In addition, WTO member governments should explicitly allow parallel importing and compulsory licensing, including the grounds for compulsory licensing, in national laws.

Pressure from the U.S. has made securing the possibility to take advantage flexibilities in the TRIPs agreement difficult for some countries. Despite commitment made by WTO members to take a pro-health approach to patent laws, the United States has used technical assistance to developing countries and bilateral trade agreements to pressure governments to adopt 'TRIPs Plus' patent laws that require greater patent protection than TRIPs. The 2003 Free Trade Agreement with Singapore contains powerful TRIPs Plus provisions and has been cited as a template for future patent protection regulations in U.S. trade agreements.⁴⁸ The Free Trade Agreement limits the situations in which the Singapore government can issue compulsory licenses for pharmaceutical production and requires the U.S. and Singapore to allow patent holders to block parallel importation into these two markets.⁴⁹

Conclusion:

In sum, health sector reforms implemented by the World Bank and the IMF as part of broader programmes of structural adjustment, and the GATS and TRIPS agreements reached by the WTO – all heavily informed by neoliberal ideology - have had a largely detrimental effect on access to sexual and reproductive health care services and information, and thus on achievement of the ICPD PoA reproductive health goals in general.

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Part III: World Trade Organization Agreements: The General Agreement on Trade in Services (GATS) and the Trade Related Aspects of Intellectual Property Rights (TRIPs)

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