The Wrong Model

GATS, trade liberalisation and children's right to health

John Hilary

Save the Children

Save the Children is the UK's leading international children's charity. Working in more than 70 countries, we run emergency relief alongside long-term development and prevention work to help children, their families and communities to be self-sufficient.

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Acronyms

CSI – Coalition of Service Industries (US)

DPT – diphtheria, pertussis and tetanus

EU – European Union

FDI – foreign direct investment

GATS – General Agreement on Trade in Services

GATT – General Agreement on Tariffs and Trade

HMO – health maintenance organisation

IMF – International Monetary Fund

OECD – Organisation for Economic Co-operation and Development

TRIMS – Trade-Related Investment Measures

TRIPS – Trade-Related Intellectual Property Rights

UNCTAD – United Nations Conference on Trade and Development

WHO – World Health Organization

WTO – World Trade Organization

Executive summary

In an era of unprecedented global wealth, millions of children across the world are facing a health crisis. A total of 150 million children still grow up malnourished, prevented from developing to their full mental and physical potential. Every year over 10 million children die from readily preventable causes. While the international community has set challenging targets for reducing child mortality and morbidity, in many of the world's countries the situation is getting worse, not better.

Much of this health crisis reflects the underlying economic reality of globalisation. The greatest gains from trade liberalisation have accrued to the wealthiest nations, and to the most powerful economic actors within each country. While some people within developing countries have also benefited, trade liberalisation has threatened the livelihoods of the world's most vulnerable communities by exposing them to global market forces. The resulting impoverishment of poor families across the developing world has in many instances led to increased health problems among children.

The trade liberalisation agreements of the World Trade Organization (WTO) have themselves generated specific problems for children's right to health. Through its downwards pressure on tariffs and non-tariff barriers to trade, the Agreement on Agriculture requires further liberalisation of the most sensitive markets and threatens the food security of whole communities. The WTO's TRIPS Agreement (on trade-related intellectual property rights) undermines the ability of developing countries to provide affordable medicines for their people.

The WTO's General Agreement on Trade in Services (GATS) poses its own challenges to children's right to health. While trade in services has long been recognised as a potential source of income and investment for many countries, GATS was originally conceived in order to expand business opportunities for transnational corporations. This includes opportunities in service sectors which have a direct impact on children's health: private sector health care and health insurance companies from the USA and Europe have already expanded their operations into the lucrative markets of Latin America, while European water companies aim to gain greater market access in countries across the world.

Some developing countries see increased trade in health services as a potential source of gain for their own economies. Health facilities in countries such as Cuba and India offer high standards of care to foreign consumers at prices well below those charged by the private sector in industrialised states. Other developing countries send their own medical personnel abroad to work in foreign health systems, and benefit from the remittances which they send back to their home countries.

In these limited cases, developing countries may make balance of payment gains. However, diverting resources and personnel towards foreign consumers for economic reasons leads to increased

pressure on public health systems which are in most cases already overstretched. In health terms, countries might stand to gain more from imports rather than exports of health services – as in the potential gains which telemedicine or medical technology transfer offer developing health systems.

In particular, given the shortage of official funding from donor and domestic governments alike, increased foreign investment in health services might seem a potential benefit for developing countries. The commercial presence of foreign health care companies in domestic systems is counted as trade in health services under GATS, and several companies see the expansion of investment opportunities as one of their chief gains from ongoing GATS negotiations.

Yet the commercial presence of such companies in the health sector threatens to exacerbate existing problems of equity, quality and capacity. Commercialisation of health services has already been shown to exclude whole communities from access to care, just as commercial considerations commonly exert a downwards pressure on health service quality. Moreover, instead of adding extra capacity, the commercial presence of the private sector threatens to undermine public services by drawing away key medical personnel and 'cream skimming' the healthiest and wealthiest consumers, destroying the possibility of cross-subsidisation and risk pooling on which universal access is based.

These problems are familiar in many parts of the developing world from the cost recovery programmes based on user fees which have been imposed as loan conditions by the World Bank and IMF. GATS takes this process one stage further through the commodification of health services for trade on international markets. The increased involvement of foreign companies in the health sector of developing countries threatens to raise more problems than it solves.

One key method of ensuring that the private health sector does not undermine public health objectives is through close regulation of its activities. As the World Health Organization (WHO) has attested, this is doubly important when dealing with foreign companies, especially powerful transnational corporations. Yet GATS undermines a country's ability to regulate its health services: restricting domestic regulation in order to remove 'unnecessary' trade barriers threatens to drive down regulatory standards rather than raising them to provide the best possible guarantee of public health.

There are similar threats to public health objectives under GATS market access and national treatment disciplines. Progressive liberalisation of services through successive rounds of GATS negotiations requires countries to commit an increasing number of their service sectors to the market. Yet the particular conditions of market access and national treatment rules expose public health provisions to challenge under GATS. Worse still, the 'lock-in'

feature of GATS means that liberalisation commitments are effectively irreversible once they have been made.

Whatever the advantages and disadvantages in other service sectors, Save the Children's analysis suggests that liberalisation of trade in health services is the wrong model to follow if countries wish to develop strong public health systems for all their people. In addition, the specific provisions of GATS undermine the ability of countries to implement their own public health priorities, and the Agreement must be reformed so that national policy objectives are explicitly protected. Governments must ensure that public health concerns are guaranteed absolute precedence over the economic aspects of services trade, in order to fulfil their responsibilities to children and to society as a whole.

1. The context: child health in the era of globalisation

In an era of unprecedented global wealth, millions of children across the world are facing a health crisis. Through its work in more than 70 countries worldwide, Save the Children has first hand experience of this crisis and its impact on children's development. This chapter provides an overview of child health in the context of globalisation, and examines the links between globalisation, trade liberalisation and children's rights.

The challenges to child health at the beginning of the 21st century are well summarised in Kofi Annan's keynote report to the UN General Assembly's Special Session on Children.[1] In the report the UN Secretary-General points to the significant achievements of the decade since the 1991 World Summit for Children: a halving of deaths from diarrhoea among young children, near total eradication of polio, and a 33 per cent reduction in under-5 mortality rates – one of the Summit's key targets – in 63 countries across the world (Annan 2001).

Yet alongside the successes, Annan also draws attention to the targets which have remained unfulfilled, and to a world in which many millions of children are still denied their basic right to health. Every year over 10 million children die from readily preventable causes; in 14 countries the under-5 mortality rate has actually risen over the past decade. Despite great advances during the 1980s, immunisation against diphtheria, pertussis and tetanus (DPT) has stagnated at under 75 per cent over the past 10 years, well short of the World Summit's 90 per cent target. While measles remains the number one child killer among vaccine-preventable diseases, in over 15 countries vaccination covers less than 50 per cent of the infant population.

Much of Annan's focus is on Sub-Saharan Africa, still the region with the highest child death rates. Less than half of the region's children under the age of one are fully immunised against DPT (down from 60 per cent in 1990), while the total number of malnourished children has increased during the 1990s. As a result of these pressures and the disproportionate impact of the HIV/AIDS crisis on their sub-region, children growing up in southern Africa today can expect to live shorter lives than their grandparents.

It would be misleading, however, to suggest that the problems of child health are confined to Africa alone. Two in three of the world's 150 million malnourished children live in Asia, with half of all children born in South Asia either moderately or severely underweight (UNICEF 2001). Countries in transition from socialist economies have seen dramatic increases in children's diseases: for example, the incidence of tuberculosis doubled among girls and almost trebled among boys under 14 in Kyrgyzstan between 1993 and 1998 alone (Marcus 2001). Rising levels of inequality have exacerbated child health problems in several OECD countries too.

The causes of this global health crisis for children are many and various. However, there is now a substantial body of evidence to support the central connection between child health and economic status. All major indicators show how much greater the incidence of ill health is among children in both poorer countries and poorer families (Wagstaff 2001). Indeed, poverty's key

place among the underlying determinants of health is so firmly established that the risk of ill health is now recognised as a characteristic dimension of poverty itself (World Bank 2000a).

This does not mean that economic growth alone offers a solution to the child health crisis. While external determinants may hold the key to sustained, long-term improvements in child health, it has become equally clear that the development of national health systems must be given immediate priority, not left to the indeterminate possibility of future economic success (Sen 1999). For poorer families, in particular, the basic accessibility of primary health care services will remain critical for years to come.

The 21st century thus presents a double challenge to children's right to health. Not only must the priorities of macroeconomic policy be reconfigured at the international level so that poor countries and communities are protected from the negative effects of globalisation. Equally, the overriding importance of basic services provision to poor families and their children must be acknowledged at both national and international levels, in order to fulfil governments' common responsibility to children under Article 24 of the Convention on the Rights of the Child.[2] At present, the orthodox model of trade liberalisation militates against these objectives, both in the general threat it presents to poor people's livelihoods and in the specific challenge – explored in the subsequent chapters of this report – of the General Agreement on Trade in Services (GATS).

1.1 Disaggregating the globalised world

Globalisation – the ongoing integration of domestic economies into global markets – can affect both the proximate and the underlying determinants of child health. As the World Trade Organization (WTO) extends its reach into areas formerly outside the range of international trade agreements, globalisation poses new risks and challenges to communities which have not been exposed to such external factors before. While some have been able to benefit from the new opportunities offered by globalisation, many more have been excluded from the feast.

At the international level, there is consensus that the greatest gains from globalisation have accrued to the most powerful economies. This was predicted by both UN and OECD estimates at the conclusion of the Uruguay Round of GATT in 1994. The results of that Round were forecast to lead to an extra US$200-500 billion in global income over the first seven years alone, but it was acknowledged that the vast majority of these gains would go to the industrialised countries of the North and the richer middle-income nations of the South. The outlook for the poorest was bleak: Sub-Saharan Africa was predicted to lose US$1.2 billion a year as a result of the Round (UNDP 1997).

Disaggregating the 'developing world' experience of globalisation in this way is particularly important, as many of the claims made in favour of increased trade liberalisation deliberately obscure the wide differences in experience between different countries of the South.

Some developing countries have managed to benefit from trade liberalisation in various sectors – the newly industrialised economies of East and South-East Asia are perhaps the most obvious examples, although they are not the only ones. However, most developing countries have not enjoyed the particular economic and historical circumstances which have allowed the more fortunate to rise with the tide.

Suggestions that trade liberalisation is a win-win scenario fail to present the true extent of its challenge to the world's poorest countries, which have not only missed out on the benefits of globalisation but have suffered most from its negative impacts as a result of extensive liberalisation of their own economies (Annan 2000). Crucially for the future, these marginalised states may become permanent losers. According to Jérôme Vignon, Chief Adviser at the European Commission's Forward Studies Unit:

> *The EU takes the view that, in terms of its operation, the world market, like any other, includes its share of 'market failures'. In the absence of appropriate corrective measures such as aid and support policies, certain countries will never resurface.* (Vignon 1997)

The same considerations apply at the national level, where some parts of a country are more likely to benefit from globalisation than others. Thus the Indian states of Andhra Pradesh and Punjab have managed to reduce rural poverty levels in certain areas during the liberalisation era of the 1990s, while poorer states such as Assam and Bihar have seen poverty rates rise or remain high (Jha 2000). Disparities between the coastal region of east China, which has been well placed to take advantage of trade liberalisation, and the vast hinterland are well known.

Nor does this disparity exist between geographical areas alone: the concentration of wealth which is one of globalisation's characteristic features applies to socioeconomic groups as well as to countries and regions. New Zealand, which liberalised its economy faster than any other industrialised nation during the 1980s, now has the highest inequality rate of all OECD countries (World Bank 2001). One calculation estimated that 17.8 per cent of the population had fallen below the poverty line by 1991 – "the creation of an underclass in a country that did not have one before" (Gray 1998).

Developing countries have experienced similar increases in income inequality as a result of liberalisation. In middle-income regions such as East Asia, strong economic growth has meant that these increases in inequality have not translated into absolute income losses for the poor. In predominantly low-income regions such as Sub-Saharan Africa, poor households have lost out in absolute as well as relative terms (Woodward 1998). The most dramatic consequences have been felt in the transition economies of the former Soviet Union, where sharp increases in income inequality have led to poverty and health crisis on a massive scale. It is estimated that excess mortality in Belarus, Ukraine and Russia totalled 4 million during the 1990s – a figure that "can be compared with the 9 million excess deaths recorded during the Kulak famine of 1929-33 in the Soviet Union" (Cornia 2001).

Increased sensitivity to such variations shows up important differences which are obscured even by aggregate measures of inequality such as the Gini index. Studies of specific policy impacts on lower quintiles, deciles or smaller percentiles reveal how policies which are positive on aggregate can be substantially to the detriment of particular groups. Some of the most startling revelations are precisely those related to trade liberalisation and international price movements, where "the costs of adjusting to greater openness are borne *exclusively* by the poor" (Lundberg and Squire 1999; emphasis in original).

At its keenest, this sensitivity captures important differences not only between the poor and the rest of society, but also among the poor themselves. When thresholds are adjusted to focus on those in extreme need, previously encouraging poverty reduction figures present themselves in a new light. In Nigeria, rural Kenya and rural Tanzania, for example, the incidence of income poverty fell during the 1980s but the incidence of extreme income poverty actually increased, further marginalising those who were already farthest below the poverty line (Vandemoortele 2000). Similarly, the achievements of the Labour government in raising over 1.2 million children out of poverty in Britain relate mainly to children who were marginally below the poverty threshold, not the very poor (Bradshaw 2001).

This overall trend presents an even greater challenge for the world's poorest children in the era of globalisation. As summarised by Kofi Annan in his end-decade report,

> *The pattern of growth in the 1990s meant that those children who most urgently needed a share in global prosperity were often those least likely to obtain it.* (Annan 2001)

Moreover, it is now becoming clear that the immiseration of the poorest is not simply a transitional feature of globalisation, typically characterised by the WTO and Bretton Woods institutions as temporary 'adjustment costs' which certain groups will suffer as a result of the structural changes brought about by liberalisation. On the contrary, even short-term economic shocks can have lasting intergenerational consequences, leading to persistent poverty. Instead of the convergence and redistribution postulated by neoliberal economic models, increasing income concentration to the disbenefit of the poorest has emerged as an endogenous and long-term feature of liberalisation (Berg and Taylor 2000).

1.2 Children and globalisation

Increased sensitivity to the experience of particular groups is particularly important when it comes to children's rights. While there has been much debate over the impact of globalisation on different countries and population groups, specific studies of its impact on children have remained at the basic conceptual stage (e.g. Norton et al. 2000). Many of the key factors which determine the realisation of children's rights take effect at the household level, and analysis at that level remains crucial. Yet significant nuances will be missed if the analysis is not extended to encompass the intra-household level and to take into account

children's specific vulnerabilities in the face of external threats.

For instance, increased foreign direct investment (FDI) is often heralded as one of the major potential benefits of globalisation for poorer countries in terms of capital formation, technology transfer and job opportunities. Yet even where FDI does bring increased returns to labour as per orthodox neo-classical economic theory, those returns are not likely to go initially or principally to households with children (Page 1999). While women constitute up to 90 per cent of all those working in the export processing zones set up in countries across the world to take advantage of globalisation, the vast majority are childless young women. Remittances from their earnings may boost household incomes and benefit younger siblings, but this is an indirect gain dependent upon many other variables and relevant to a small proportion of total households only.

Indeed, given the enthusiasm for FDI as a catalyst for development and poverty reduction, it is important to note how limited is its spread across the developing world. Disaggregation shows that the top 10 developing country recipients alone accounted for US$200 billion of the total US$240 billion in FDI inflows to the developing world in 2000 (a share of 83 per cent), while the least developed nations saw a 15 per cent fall in total FDI to just US$4.4 billion (UNCTAD 2001).[3] Relatively small amounts of FDI may still be important to individual countries as a source of capital; Malawi, for example, received only US$3 million in FDI during 1999, yet that sum represented 27 per cent of the country's gross fixed capital formation. In human terms, however, the effect remains highly concentrated, as transnational corporations and their affiliates employ only 2 per cent of the total workforce in the developing world (UNCTAD 1999a).

The situation is worse if this concentration of job opportunities comes at the expense of investment in other areas. In such cases the cost of seeking inclusion in the globalised economy can have particular consequences for children, as in the rural to urban migration of families. In China, for example, the stereotypical migrant worker is either a young man working on a city construction site or young woman working in a factory and living in dormitory accommodation. Yet among the more than 50 million labour migrants in China there are many whole families who have also moved to the cities in search of work. Children in these families not only live in poor conditions common to many migrant communities around the world; they have also found themselves excluded from restrictive health care systems and immunisation programmes (Zhou 2000; Vallejo Mestres 2000).

Similar challenges face children of migrant families in the Philippines (Fabe 2001). More widely, indeed, recent analysis of the East Asian economic crisis on Filipino households provides an important reminder of another key consideration when examining globalisation's impact on children's rights (Chavez 2001). While exposure to global markets has obvious risk consequences for households in general, temporary crises can have a permanent effect on children whose access to education or health care is compromised. Far more than adults, children

face long-term damage as a result of short-term restrictions to these basic services. The extra vulnerability which is characteristic of globalisation's social impact has particularly serious consequences for children's development.[4]

1.3 Food security and malnutrition

There is no better example of such long-term consequences than the threat of malnutrition. The fundamental importance of early nutrition (including *in utero*) to children's basic mental and physical development makes this an issue of even greater significance than it already is in relation to adults. The potentially negative impact of agricultural trade liberalisation on food security raises serious concern over globalisation's impact on children's right to adequate nutritional levels, not least when the number of malnourished children in Sub-Saharan Africa is forecast to rise by 18 per cent over the next 20 years (IFPRI 2001).

Agriculture remains the largest employment sector in most developing countries, and the majority of children belong to farming families. As with other sectors, there is considerable variation between individual country experiences. A handful of countries dominate the agricultural export trade in each continent: Brazil, Argentina, Mexico, Chile and Colombia account for three quarters of agricultural exports in Latin America, while China, Thailand, Malaysia, Indonesia and India account for 70 per cent in Asia. In Africa, with total agricultural exports valuing well below those in the other two regions, there is less concentration: South Africa, Morocco, Kenya, Zimbabwe and Egypt account for 38 per cent of the total (WTO 2000a).

Over and above these regional aggregates, individual countries do compete on the international stage in specific products: Vietnam, for example, accounts for around 15 per cent of world rice exports; Cuba still commands almost 9 per cent of the world sugar market (WTO 2000b). In addition, agricultural exports remain important to some countries' individual trade balances: food items and agricultural raw materials represent over 80 per cent of the limited export sectors of such countries as Burkina Faso, Ethiopia, Malawi, Nicaragua, Paraguay and the Pacific island states (UNCTAD 2000a).

Yet at the household level, where the effect on children is most directly experienced, exports represent a minor part of the agricultural sector in most developing countries. The great majority of agricultural activity is for subsistence or local trade – even crops such as bananas are predominantly for domestic consumption, with under 20 per cent of world production exported. While export-led strategies may offer new opportunities in certain subsectors such as horticulture, the direct benefits of globalisation to low-income agricultural producers and their families are likely to be "very limited" (Woodward 1996).

The risks, on the other hand, may be considerable. Many communities have already experienced severe challenges to their food security as a result of trade liberalisation, often in the context of structural adjustment programmes imposed by the World Bank and IMF. Removal of

subsidies and reduction of tariffs have exposed farmers to the full impact of market forces, at a time when their incomes are under attack from increased competition and declining terms of trade. In countries as diverse as Mexico, Uruguay, Zimbabwe, Kenya, India and the Philippines this has led to widespread impoverishment amongst many of the most vulnerable farming communities (Murphy 1999; Chisvo 2000; Madeley 2000).

Households whose livelihoods are closely tied to one particular sector – for example, families dependent upon primary commodities such as coffee – are particularly vulnerable to such challenges:

> *Perhaps the most direct effect of trade reform on poverty is via the prices of goods/services in which poor households have large net positions. The largest price shocks occur when either the initial or final price is finite and the other infinite (i.e. when there is no market). A shock that completely undermines an important market – e.g. for a cash crop or a form of labour – is likely to have major poverty implications.* (Winters 2000)

If, as often, they are net purchasers of food, poor rural families may benefit briefly from a drop in prices caused by cheaper imports. However, since such households predominantly rely on their labour to earn the money to buy food, the undermining of local markets will jeopardise their employment opportunities and leave them without their primary source of income.[5] Ultimately this leaves poor families unable to satisfy their basic food needs, driving many to migrate to towns and cities, where their additional presence threatens the livelihoods of the urban poor in turn.

As a result of these concerns, several WTO member states have presented a joint proposal to the WTO's current negotiations on the Agreement on Agriculture, recommending that developing countries be allowed to re-evaluate and raise tariff bindings on key products in order to protect national food security, with the option of using a positive list approach to exempt sensitive agricultural products or sectors from the Agreement altogether (Cuba et al. 2000). Similarly, the Africa Group of WTO member states has proposed that developing countries be given the option of retaining bound rates on key staples at current levels, not reducing them as required by the Agreement (Africa Group 2001). Whatever solution is finally adopted out of these and other proposals (e.g. Green and Priyadarshi 2001), it is clear that an enhanced use of special and differential treatment is required within the Agreement on Agriculture in order to safeguard food security and child nutrition from the worst effects of trade liberalisation.

It should also be noted, in the context of this report, that GATS has its own impact on food security. In the celebrated case brought by the USA and several Central American countries against the EU's banana importation regime, the WTO disputes settlement panel ruled that the 'most favoured nation' provisions of GATS applied just as much as those of GATT. While the EU argued that the import licensing procedures related to trade in goods (bananas) and should therefore not come under an

agreement governing trade in services, the WTO ruling – which was upheld on appeal – found that the licensing procedures did concern trade in services in that they affected the wholesale distribution of bananas, and as such were indeed covered by GATS (WTO 1997). The devastating impact the ruling will have on tens of thousands of households in the Caribbean has been well documented elsewhere (e.g. Godfrey 1998).

1.4 Education: a health issue

While the scope of the present report prohibits a proper analysis of education in the era of globalisation, the established link between education levels and child health makes it an important contextual issue. Infants born to mothers with no formal education are twice as likely to die before their first birthday as those born to mothers with post-primary school education (UNICEF 2001). In Africa, female literacy has been calculated to have an impact on infant and child mortality comparable with that of income levels and access to health care (Cornia and Mwabu 1997).

Many of the pressures currently facing health systems across the world also apply to educational systems. On average, basic education absorbs two thirds of public spending on social services in developing countries – twice as much as the totals spent on health, nutrition, water and sanitation together. At the household level, particularly for families with several children, formal or informal charges mean that education will commonly represent a major part of non-food expenditure, and is often beyond the reach of the poor. The introduction of even modest user fees has led directly to a decline in primary school enrolment levels in several countries, particularly for girls. Conversely, the abolition of user fees in Malawi saw a 50 per cent rise in primary enrolment almost overnight (Vandemoortele 2000).

There is concern that the global trend towards commodification of basic services threatens children's right to education in much the same way as it threatens health care. In particular, the WTO's move to liberalise trade in services presents a potential threat to publicly funded education, notably in those 40 countries – among them Lesotho, Jamaica, Ghana, Thailand and The Gambia – which have made commitments under GATS to liberalise their education sectors (EI and PSI 1999). The Third World Congress of Education International, held in July 2001, closed with a resolution specifically opposing the inclusion of education in ongoing GATS negotiations.

1.5 TRIPS and access to medicines

If education levels represent a telling determinant of child health in the long term, access to medical care is a more immediate concern for families faced with childhood illness. Expenditure on medicines accounts for a major proportion of health costs in developing countries, so that access to effective health care is heavily dependent on the availability of affordable drugs. Yet it is estimated that a third of the developing world's population is unable to find or purchase essential medicines on a regular basis, and that in parts

of Africa and Asia more than half the population lack access to basic essential drugs (WHO 1999).

Under the WTO's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), even this limited access to essential medicines has come under threat. The TRIPS Agreement requires all WTO member states to introduce restrictive intellectual property regimes which grant extensive patent rights to pharmaceutical companies. This effectively denies developing countries the right to manufacture or buy generic versions of brand-name drugs, a system which has traditionally given millions of people in the developing world access to essential medicines at a fraction of the price charged by transnational pharmaceutical corporations. As a result of these new restrictions, TRIPS "makes access to essential life-saving drugs impossible for low-income countries, regardless of their level of public health expenditure" (Cornia 2001). The UN Development Programme has questioned the compatibility of the TRIPS Agreement with human rights law (UNDP 2000).

High-profile court cases and campaigns during 2001 have focused international attention on the issue of TRIPS and public health. Under pressure from worldwide public opinion, the group of 39 pharmaceutical companies which had challenged South Africa's 1997 Medicines Act as a violation of their patent rights were forced to abandon the case in April 2001. Two months later, the US government dropped its call for a WTO disputes settlement panel to rule on Brazil's legal requirement that pharmaceutical companies manufacture their products locally if they are to enjoy exclusive patents – another measure which, the USA claimed, was incompatible with TRIPS.

Alongside these individual developments, the WTO's TRIPS Council has held special discussions to determine the right of governments to prioritise public health goals over corporate patents. Instigated by the Africa Group of WTO member states, these discussions have aimed to clarify and strengthen the public health safeguards within the TRIPS Agreement in advance of the WTO's Fourth Ministerial Conference.

Access to affordable medicines – both treatments and vaccines – is critical for children's right to health. As stressed by the group of developing countries at the TRIPS Council's first special discussion in June 2001, governments must be allowed to retain genuine flexibility in compulsory licensing or parallel importation of medicines in order to protect that right. The ambiguity of the TRIPS Agreement in its current form undermines governments' ability to intervene on public health grounds, not only as a result of the challenges they could face under the WTO's disputes settlement system but also in view of their vulnerability to extraneous political pressure from economically powerful states. This ambiguity has led to calls for the TRIPS text to be revised in order to include explicit safeguards on public health (Bailey et al. 2001).

1.6 Collapsing health systems

Even with the cheapest medicines, many countries would still find themselves unable to guarantee children's access to health care. In several of the

world's poorest countries, particularly in Africa, the systems needed to deliver that health care have all but collapsed (Simms et al. 2001). In this respect, one of the greatest challenges facing the international community is to ensure adequate and sustainable financing mechanisms to build up the capacity of health systems, both as an immediate priority and into the long-term future.

Most individual governments retain sufficient budgetary capability to influence outcomes at the national level. Countries which have outstripped their regional peers in terms of social progress – including health outcomes – are characterised by higher levels of government expenditure on health and education in per capita terms, and by the fact that those levels have been maintained even in the face of economic crisis. It has become increasingly clear that investment in basic services must be made an immediate priority at the national level, rather than predicated on the prospect of economic growth (Mehrotra 2000).[6]

Much of the erosion of health systems has come as a result of public expenditure cuts introduced under the structural adjustment programmes of the IMF and World Bank. Yet liberalisation policies have also restricted governments' ability to intervene in support of public health systems, as a result of the fiscal squeeze brought about by reductions in revenue from tariff and non-tariff duties. Several countries have already experienced a significant contraction in this regard: Jordan has seen international trade taxes decline from 48 per cent of total government revenue in 1980 to 23 per cent in 1997; Sri Lanka has seen a fall from 50 to 16 per cent in the same period; Botswana from 39 to 12 per cent (World Bank 2000b). Few countries have managed to offset the negative effect of tariff reductions by means of a corresponding expansion in their total value of trade.

The impact of such reductions is magnified at a time when other sources of funding for basic services remain scarce. The proportion of official development assistance devoted to basic health and education has remained at around 10 per cent of a total which has declined dramatically over the past 20 years. Multilateral creditors allocate even less of their assistance to basic services: in 1999 the World Bank gave less than 4 per cent of its total development finance to basic health, basic education, water and sanitation, with basic health representing just 0.1 per cent of total World Bank assistance (OECD 2001). All fall well short of the international community's repeated commitment to a 20 per cent allocation of aid to basic services, while the global shortfall in annual public spending on basic services has more than doubled to US$90 billion in the short time since the 20/20 Initiative was launched in 1995 (Annan 2001; UNICEF et al. 1998).

Given the challenges which globalisation presents to the most vulnerable families, it is crucial that all children have access to basic services if they are to realise their fundamental rights. Recognition of the importance of this access underlies the growing concern that public services such as health care may come under threat from the liberalisation of trade in services. Precisely this liberalisation of trade in services is the primary goal of GATS.

2. GATS and increased trade in health services

The introduction of services into the Uruguay Round of GATT opened a new chapter in the history of international trade negotiations. Along with the agreements on trade-related investment measures (TRIMS) and intellectual property rights (TRIPS), GATS marked the expansion of liberalisation into areas which had previously been considered outside the remit of trade talks. Despite resistance from developing countries, concerted pressure from US and European negotiators ensured GATS was an integral part of the WTO agreements which comprise the Uruguay Round's Final Act.

The WTO has made no secret of the fact that GATS was crafted at the instigation of the corporate sector. In the words of David Hartridge, former Director of the WTO's Trade in Services Division:

> *Without the enormous pressure generated by the American financial services sector, particularly companies like American Express and Citicorp, there would have been no services agreement.* (Hartridge 1997)[7]

The European Commission is equally clear that GATS exists primarily as a means to further corporate interests:

> *The GATS is not just something that exists between governments. It is first and foremost an instrument for the benefit of business, and not only for business in general, but for individual services companies wishing to export services or to invest and operate abroad.* (European Commission 1999)

As a result of this acknowledged bias towards the interests of established services companies in industrialised countries, many commentators from the developing world see GATS in its present form as offering little to their own economies (e.g. Das 1998). Moreover, UNCTAD's assessment of the state of international services trade found that developing countries had made little progress in challenging the industrialised world's dominant share of services exports in the years since the adoption of GATS (UNCTAD 1999b).

Nonetheless, several developing countries have identified services as an important growth area. For developing economies whose terms of trade continue to suffer through overdependence on primary commodities, the importance of the services sector as a means of export diversification has long been recognised (UNCTAD 1996). Labour-intensive service industries offer some countries a particular economic advantage, at the same time as providing increased employment and linkage opportunities. In many developing countries, indeed, the services sector has already grown to be a major source of formal employment, representing over 50 per cent of the labour force in countries as diverse as Brazil, Lebanon, Nigeria, South Africa and the Bahamas (UNCTAD 2000a). Services also account for much of the increase in women's labour force participation in North Africa, Latin America and the Caribbean (World Bank 2000b).

Tourism has traditionally been seen as the sector with the greatest potential for developing countries to increase their export earnings – indeed, countries such as Algeria, Burkina Faso,

Tanzania and Uganda have limited their GATS liberalisation commitments to the tourism sector alone. However, for countries which have basic educational standards, communications infrastructure and specific advantages such as English language capability, trade in services offers other possibilities. In Barbados, for example, which has seen major expansion in the new data processing sector, services exports now earn around US$1 billion a year, four times the value of the country's goods exports (UNCTAD 2000a).

Expansion of services exports may offer balance of payment gains to developing countries, as well as beneficial linkages to other parts of the economy. Yet the new employment opportunities from an expanding services sector typically fall to skilled workers, not the unskilled. Growth in services is therefore symptomatic of the globalisation process in general, with its increasing returns to education and the displacement of unskilled labour (Cornia 1999). This in turn leads to increased inequality and its attendant problems, given that the unskilled are already overrepresented among the poor. In India, indeed, the growth of the services sector has itself been identified as one of the three major causes of rising inequality in the post-1991 reform period (Jha 2000).

2.1 Trade in health services

As with those labour-intensive services mentioned above, the health sector offers some developing countries increased export potential at the same time as it raises other, more problematic social issues. Unlike most other services, however, the direct impact on public health priorities makes health trade liberalisation a critical issue in terms of children's rights. The rest of this chapter examines the potential gains and losses to developing countries from increased trade in health services, broken down according to the four GATS modes of supply:

1) **cross-border supply**: – where the service is provided remotely from one country to another (e.g. international telephone calls, Internet services, telemedicine)
2) **consumption abroad**: – where individuals use a service in another country (e.g. tourists travelling abroad, patients taking advantage of health care in foreign countries)
3) **commercial presence**: – where a foreign company sets up a subsidiary or branch within another country in order to deliver the service locally (e.g. banks, private health clinics)
4) **presence of natural persons**: – where individuals travel to another country to supply a service there on a temporary basis (e.g. software programmers, nurses, doctors)

According to one estimate of modal shares across all sectors, modes 1 and 3 each account for around 40 per cent of total services trade and mode 2 for around 20 per cent. Mode 4 remains insignificant in relation to total world services trade, even though it may be of some importance to individual economies (Karsenty 2000). Other estimates – necessarily speculative, given the inadequacy of statistics on services trade – suggest that mode 3 accounts for over half of all trade in services on its own (Stephenson 1999).

It is unclear to what extent trade in health services follows this overall pattern.[8] Health services trade

has developed to a limited extent in comparison with other service sectors, and the opportunities for increasing that trade could alter the balance of modal shares significantly, depending on the level of liberalisation achieved for each. Such developments in turn have the potential for significant impact on children's right to health: as the analysis below reveals, increased trade in health services entails specific economic and health consequences depending on the mode of supply.

2.1.1 Mode 1: cross-border supply

The most intriguing example of cross-border trade in health services is telemedicine: the provision of medical services from a practitioner in one country to a patient or practitioner in another, predominantly via Internet or satellite transmission of medical images. While still in its infancy, the potential benefits of telemedicine are already becoming evident within countries, especially for remote diagnosis and treatment. Based on evidence from its use among remote rural communities in Japan and Australia, telemedicine could expand the capacity of doctors in developing countries:

> *For example, the present five Ethiopian expert radiologists who travel to different parts of the country to cover the basic essential services could multiply their output three or fourfold if the radiological images 'travel' to them via telecommunications.* (Mandil 1998)

Such a scenario presupposes a communications infrastructure developed to a level far higher than is currently found in most remote areas of the developing world. However, there are already several examples of telemedicine working internally within developing countries, even on an experimental basis. One study in the Dominican Republic established a telemedicine link between two sites which included interactive video conferencing to transmit medical images for remote diagnosis and proposed treatment. In Mexico, a satellite link enables specialists in the major 20 November Hospital in Mexico City to support general practitioners in 10 rural hospitals in the Chiapas region. Similar video conferencing or image transmission facilities have been set up between metropolitan and remote hospitals in Thailand, Argentina, Malaysia and Mozambique.

Transmission of such images across national borders is often as easy as within them, and early potential for cross-border trade in telemedicine is already being realised. The King Faisal Specialist Hospital and Research Centre in Saudi Arabia has established a commercial link with several US hospitals for the provision of routine diagnosis and second opinions, even (via video conferencing) in emergency situations. The King Hussein Medical Centre in Jordan has also established a satellite link with the Mayo Clinics in the USA for second opinions in complex cases.

Similar links have been developed between university hospitals in Japan and health care sites in Cambodia, Fiji, Papua New Guinea and Thailand. However, it should be noted that these are maintained on a non-commercial basis, as are many of the pilot projects which have been tried to date (Wright 1998). While there is a growing body of evidence to attest the clinical benefit and

cost-effectiveness of telemedicine (e.g. Wootton 2001), there is less proof of its commercial sustainability.

Telemedicine also includes the remote provision of medical education. Teleconferencing has already been established between institutions in Canada, Kenya and Uganda to enable health care workers in Africa to benefit from the latest medical knowledge. Internet websites such as the University of Iowa's Virtual Hospital provide free online information on a wide range of adult and child health problems – a valuable resource for doctors otherwise reliant upon outdated collections of medical journals (Edworthy 2001).

In all these cases, the expansion of cross-border supply of telemedicine offers potential gains for health care. Concerns remain over patient confidentiality and the applicability of medical information generated in industrialised countries to situations in the developing world. In addition, there is the problem of regulatory control over telemedicine, as noted by the 50th World Health Assembly in its 1997 resolution on the uncontrolled sale of prescription drugs over the Internet. The resolution focused on the public health hazard of counterfeit products being passed off as genuine, and on the inappropriate use of potentially dangerous medicines without medical supervision (WHO had already exposed four companies selling prescription drugs over the Internet without the detailed information which should accompany them).

Telemedicine poses regulatory challenges on the demand as well as the supply side. Even the most advanced regulatory systems would be unable to prevent doctors or clinics from ordering medicines over the Internet which are not included in a country's essential drugs list. Such practices might give those practitioners a perceived commercial edge over rivals who kept within treatment guidelines, but would undermine national policies promoting the rational use of drugs.

These problems could be largely avoided in cases of links between hospitals or other health care centres. Perhaps of greater concern is the potential drain which commercial cross-border trade in telemedicine could have on limited health care budgets in developing countries. At present almost all trade in remote health care is from North to South, and the expense of entering into commercial relationships would be prohibitive for most poorer nations. While the technology of telemedicine offers potential benefits in some cases, few would suggest its commercial development offers more general solutions to the health problems of the majority.

Of more immediate significance is the development of cross-border private medical insurance and managed health care. While most private health insurance is provided by companies with a commercial presence in the country concerned (and thus covered by mode 3 of GATS), there is increasing potential for such services to be provided across national borders. However, the issues remain substantially the same as those discussed below in connection with mode 3: the increased commercialisation of health care and the growing involvement of the private sector.

2.1.2 Mode 2: consumption abroad

Patients consuming medical services abroad represent a more significant source of international trade in health services, whether they have travelled abroad especially to seek medical treatment in another country or happen to have needed treatment while visiting that country for other reasons. The majority of the USA's estimated US$872 million in health care exports in 1996 came from foreigners being treated in the country; conversely, Argentinians are estimated to spend US$60 million annually on medical treatment abroad (WTO 1998).

The potential for developing countries to gain economic benefit from attracting foreign consumption of their health services is limited. As the WTO notes,

> *[O]nly a relatively small number of economically advanced developing countries, preferably located in the vicinity of major 'export markets', may be able to benefit significantly from mode-2 trade in this sector.* (WTO 1999a)

However, certain countries have identified provision of health services to foreigners as a potential growth area. Pursuing a strategy to establish the country as a world medical power, the Cuban government has set up Servimed as an agency dedicated to developing health tourism packages for foreigners. In 1995/96 a total of 25,000 patients from North and Latin America travelled to Cuba to take advantage of its low cost, high quality medical care, bringing the economy US$25 million in exports. Similarly, India offers significant cost advantages for patients travelling from industrialised countries, with major treatments such as liver transplants or coronary bypass surgery priced at a tenth of what individuals would be charged in the USA (Mattoo 1999).

Even countries without the capacity to compete in the international health care market have established themselves as key health service destinations at the regional level. Jordan has invested heavily in its health system as a means to becoming the medical centre of the Arab world, including the opening of 11 new private hospitals over the past decade (UNCTAD 1997). In East Africa, Kenya's high quality medical care attracts patients from neighbouring Uganda and Tanzania (Ikiara et al. 2001).

In addition, certain countries offer culturally specific health services. Traditional Chinese medicine draws a substantial number of patients to China every year, the majority of them overseas Chinese but also a growing number of individuals who have turned away from the Western medical tradition. India has a similar advantage in its extensive network of Ayurvedic practitioners, who attract a steady trickle of foreigners every year. The Ayur Vaidya Sala at Kottakal in Kerala is already well known in Germany, Malaysia, USA, UK and the Gulf states (Gupta et al. 1998).

The other side to consumption of health services abroad is the training of medical students at foreign educational institutions. Countries such as the UK and USA have long traditions of providing such education to foreign students on a commercial basis, while China and Brazil have in the past tended to offer training in the framework of technical co-operation programmes. Once

again, certain countries have the ability to attract foreign students for culturally specific courses, such as training in Ayurvedic or traditional Chinese medicine. Some German universities now give students credits for courses taken in institutions in China (UNCTAD 1997).

In these limited cases, the consumption of domestic services by foreigners represents a potential source of export earnings for the host country – and an important one for under-diversified economies such as that of Cuba. However, these benefits will be outweighed by the social costs if limited investment is drawn away from national health priorities. In the vast majority of countries, an expanding private sector will draw medical personnel away from the public sector, with the result that favouring foreign patients will come at the expense of the local population. While extra investment financed by charges on foreign consumers has the potential to upgrade services for local users, in practice the two groups often use separate facilities, with little opportunity for cross-over (Adams and Kinnon 1997). Worse still, the public sector often has to bear the cost of building the new hospitals and clinics to treat foreign patients – a further diversion of resources away from public health needs.

A lesser threat applies to those countries which provide education to foreign medical students, given that there is greater elasticity of supply than in the case of health care. However, the economic imperative to raise numbers of paying foreign students has the potential to drive down the quality of training as a result of declining teacher to student ratios and rising pressure on resources. Ultimately there may be a parallel threat to that experienced by patients: reduced opportunity of access for domestic students and a consequent contraction in the numbers of qualified nationals.

The reverse situation pertains for those countries which send medical students for training abroad. In such cases the training represents an import in balance of payment terms, but can be seen as an investment in terms of the obvious potential for skills transfer. However, the extent to which those skills can be deployed to the benefit of the wider society depends on how many of the trainees return to their home country once their courses are over. Only half of Indian doctors trained in Europe and the USA return home at the end of their training (Gupta et al. 1998).

2.1.3 Mode 3: commercial presence

The establishment of commercial presence in a foreign country differs from the other three GATS modes in that it is essentially an issue of investment. In health care, this investment relates primarily to foreign commercial presence in hospitals, health clinics and health insurance, and to a lesser extent in the provision of medical education. As noted above, GATS aims to generate new opportunities for service companies to invest and operate in the service sectors of other countries. Yet the prospect of increased foreign commercial presence in the health sector has raised serious concerns in relation to children's right to health, given the negative experience of fee charging in the sector to date.

EQUITY

In the developing world, much of this experience has come as a result of the liberalisation process

in those countries which have implemented structural adjustment programmes under the IMF and World Bank. The introduction of cost recovery programmes in the health sector is now widely accepted to have been disastrous, forcing many poor families and their children into a 'medical poverty trap' characterised by untreated illness and long-term impoverishment (Whitehead et al. 2001). Even the World Bank, while it continues to support user fees for health in national Poverty Reduction Strategy Papers, has acknowledged that they are responsible for denying poor families access to health care (World Bank 2000a).[9]

Two examples typify the consequences of cost recovery programmes for children's health. In Zimbabwe, which made significant health gains during the 1980s, the introduction of user fees led to a 12 per cent decline in the total percentage of children receiving BCG vaccination and a 14 per cent fall in the percentage receiving three doses of the polio vaccine. Falling attendance at health facilities across the country was accompanied by a resurgence of childhood diseases such as measles. Both the infant mortality rate, which had been halved during the 1980s, and the child mortality rate began to rise again (Mwanza 1999).

In Vietnam, likewise known for its achievements in sustaining low infant and maternal mortality rates in the pre-liberalisation period, the introduction of user fees has led to greatly increased inequality in access to health care between rich and poor families. Half of poor households with a family member needing medical care are now forced to borrow money or sell livestock to meet the ensuing expenses, with chronic illness leading to severe indebtedness. As a result many have simply kept their children away from health clinics, with a 50 per cent reduction in the number of public health care consultations in the first seven years following the introduction of liberalisation in 1986. Some remote mountainous areas have such low usage levels that the health system has effectively ceased to function there. While the 1994 under-5 mortality rate was 44 per 1,000 in the Red River Delta, it was 108 per 1,000 in the central highlands and 82 per 1,000 in the northern highlands of Vietnam (Malhotra 1998).

This exclusion of vulnerable families from access to health care has been a typical experience of cost recovery programmes, and exemption systems have generally been ineffective in protecting the poor. For children in particular, the introduction of fee charging raises additional issues of empowerment: even in those cases where there are sufficient household resources available, diverting them to meet medical expenses is a choice over which children rarely have control. Increased exposure to charges, particularly where access to health care has previously been free at the point of delivery, places children at a further remove from access to health care.

Structural adjustment programmes have introduced cost recovery principles into the health care sector in many countries. Yet GATS goes one stage further, as it represents the commodification of health care for trade on the open market. Just as internal liberalisation prepares the way for commercialisation of the health sector, so too external liberalisation locks

in commercialisation through the long-term presence of foreign investment.

For developing countries with failing health systems, this foreign investment may seem an attractive source of capital and medical technology at a time when other sources are thin on the ground. Yet involvement of the foreign private sector in health care has the potential to marginalise the poor even further. Companies seek markets in which they can be assured sufficient returns, and this typically concentrates investment in more affluent areas. Loans granted to private health care providers by the World Bank's International Finance Corporation, for instance, are predominantly directed towards facilities for the richer communities of the country in question or for expatriates, not the majority of the population (Hall 2001a).

This practice of 'cream skimming' by the private sector is already familiar from the field of private health insurance, where insurance companies and health maintenance organisations (HMOs) typically favour the healthy and wealthy over high-risk customers, excluding the latter by means of prohibitive premiums.[10] In terms of direct health care provision, similarly, the private sector's profit-making imperative makes it of limited relevance to those sections of society which are unable to pay for its services, even though it is they who need the extra investment most.

Yet private investment in health care is not simply an irrelevance to poor people. In many countries, as noted above, an expanding private sector will draw personnel away from public health systems and exacerbate shortages of trained and qualified staff, precisely as witnessed in Thailand, for example, during the 1980s and 1990s (Sitthi-amorn et al. 2001). Often it is the most skilled staff who make the move to the private sector, lowering the overall quality of personnel in the public health system.

Worse still, cream skimming undermines the very ability of public health systems to sustain themselves financially, as it denies the basic principles of cross-subsidisation and risk pooling by which the healthy support the ill, the young the old and the rich the poor:

> *Experience in the USA and more recently in Latin America is that the viability of public and voluntary hospitals and health services is threatened when they have to compete with commercial providers for per-person public funds, private insurance, and copayments. Typically, the public sector has been left to bear the risk for more vulnerable populations but with diminished risk pools (or pooled funding) to finance care.* (Price et al. 1999)[11]

Foreign investment also brings with it the risk of domination by transnational corporations to the exclusion of domestic development. In the hospital sector, the overwhelming majority of these corporations are powerful companies based in Europe and the USA, with only Singapore's Parkway Holdings (owners of London's Heart Hospital until its reacquisition by the government in August 2001) and South Africa's Afrox Healthcare as exceptions. Precisely this domination by powerful foreign companies was a key factor behind developing countries' unwillingness to commit more of their

service sectors to liberalisation under GATS (Ahmad 1999).

Already in the case of Kenya, for example, doctors in Mombasa complain of the domination of medical services by African Air Rescue and the Aga Khan Hospital, and of a parallel foreign domination of medical insurance services by means of the managed care system (Ikiara et al. 2001). Crucially, one of the factors identified as being responsible for allowing foreign companies to dominate the health insurance sector is the "inefficiency and limited scope" of Kenya's public National Hospital Insurance Fund. In many countries with non-functioning health systems, the involvement of the private sector is represented as necessary because of the extra capacity it offers over and above the public health service.

Most industrialised countries already enjoy successful public health systems based on social health insurance or taxation. To Europeans and others imbued with a belief in the universal right to health care according to need, the prospect of a commercialised health system along US lines raises considerable cause for concern. According to the US Census Bureau, 10 million children in the USA – many of them from low-income families – remain uncovered by either private insurance or Medicaid and thus exist effectively outside the medical system. Given the significant socioeconomic gradients in child mortality and morbidity which already exist in countries such as Britain, any reduction in access to health care as a result of increased commercialisation would be a serious challenge to public health objectives.

QUALITY

As well as the equity issues raised by commercialisation, liberalisation also risks compromising the quality of health care delivery. The introduction of private sector companies into public health systems raises potential conflicts of interest between commercial pressures and public health goals. In industrialised countries this has commonly meant a reduction in quality as a result of cost-cutting, often through a substitution of casual for skilled labour amongst nursing and ancillary staff. It has also led to the planning of hospitals on the basis of financial rather than clinical need, with accompanying reductions in the clinical workforce and service capacity (Gaffney et al. 1999).

In the USA, where the health care market has become increasingly competitive over time, HMOs have responded by pressurising doctors to withhold treatment from their patients. By means of performance-related pay mechanisms linking their incomes directly to the clinical costs they incur, doctors are encouraged to refer the lowest possible number of patients to specialists or to hospitals. Bonuses are awarded to those who minimise such expenditure, while doctors who generate above-average costs risk expulsion by the HMO (Kuttner 1998).

In developing countries, commercial pressures lead to similar profit maximisation strategies. One study of private clinics in Malaysia revealed that many fail to assess new clients properly in their provision of family planning services, with cervical screening undertaken only if requested. Conversely, private practitioners in Egypt have been found to be less likely than public sector

workers to administer (inexpensive) oral rehydration solution, and more likely to prescribe antidiarrhoeal drugs – even though the latter are contraindicated in the country's national programme (Swan and Zwi 1997).

The decision to involve foreign companies in the health sector requires very definite structural conditions if it is not to damage the quality of health care delivery in systems which are already under severe strain. As many commentators have stressed, national and regional health authorities need highly developed regulatory, analytical and managerial capacity if they are to see any benefit from the "radical challenge" of working with foreign companies (Kinnon 1995; UNCTAD 1999b).

In the majority of poorer countries, however, this capacity is simply non-existent. As a result, the introduction of private sector investment threatens to divert care away from public health priorities and to compromise quality of health care delivery further. Concerns that profit-led health care is excessively focused on curative rather than preventive measures are familiar and longstanding, as are fears of over-prescription and unnecessary treatment undertaken for financial motives. Even joint public-private initiatives based on donations or price discounts have revealed their own shortcomings, distorting national health strategies and diverting funds towards non-priority areas, as well as hindering the development of national health systems as a whole (Heaton 2001).

The acknowledged difficulties of integrating private sector companies into public health care have sown doubts among even the most pro-liberalisation commentators. Staff members of the WTO's Trade in Services Division, writing in their private capacity, admit that the theoretical efficiency gains to be made from health trade liberalisation leave significant questions unanswered:

> *[W]hile such trade/efficiency links appear appealing to economists, at least within an appropriate regulatory environment, doubts may remain as to the effects of stiffening competition on other core policy concerns in the health sector, such as quality and the alleviation of poverty.* (Adlung and Carzaniga 2001)

Moreover, as far as the objectives of health services are concerned, the efficiency of the private sector is unsubstantiated. Patterns of health care consumption resemble those for luxury goods, with high-income households spending a higher proportion of their income on health care than poor households. Poor households therefore account for the majority of health needs but a disproportionate minority share of health expenditure, so that the use of resources in the private health care market is doubly skewed away from need. Precisely this inverted relation between supply and demand renders the market inefficient (Smithson 1994).

2.1.4 Mode 4: presence of natural persons

If the establishment of commercial presence is primarily of interest to transnational corporations from industrialised countries, the temporary movement of 'natural persons' to provide a service abroad has generated most interest among developing countries. There is already substantial

movement of medical personnel from South to North and between countries of the developing world (health services, unlike many other professional services, being largely based on universal principles). However, the perceived economic benefits of this trade raise serious concerns for children's right to health, especially in the poorest countries.

The potential for exchange of medical personnel between countries is attested by experience from across the world. Developing countries – particularly from Asia – supply over half of all migrating physicians, with around 100,000 doctors of Indian origin settled in the USA and UK alone (Gupta et al. 1998).[12] While there are 4,000 physicians in Kenya, there are 700 Kenyan doctors working in South Africa, and more in Botswana and Swaziland (Ikiara et al. 2001). Chinese medical teams continued to work in 38 developing countries during the 1990s, with individual nurses and doctors in several more (Xing 1998).

Active international recruitment by national health systems has generated a particularly high level of cross-border mobility among nurses. Europe has recruited nurses from as far afield as the Philippines, India and Argentina; North America has traditionally drawn from Latin America, Europe and the Caribbean. The Middle East, which relies heavily on nurses educated elsewhere, recruits from Australia, Canada, India, Kenya, Malaysia, New Zealand, the Philippines, Trinidad and Tobago and several European countries (Oulton 1998).

This international recruitment enables importing countries to offset shortages in their own stock of qualified personnel with nurses from countries with routine surpluses, such as the Philippines. While this may appear to be a logical market solution, it has also allowed governments in some countries to avoid addressing key problems in the domestic career structure, and to depress standards in the profession (ICN 1999).

More critically, a large number of those countries which export doctors and nurses experience severe shortages themselves, and can ill afford to send their services abroad. Countries such as Jamaica and South Africa have suffered a shortage of public sector health workers as a direct result of the mass migration of medical personnel to North America and the UK. The problem is often particularly acute among specialist doctors: 56 per cent of Ethiopian pathology graduates from the Addis Ababa Faculty of Medicine between 1984 and 1994 left the country (Adams and Kinnon 1997).

There is now widespread criticism in Britain of health sector employers' active 'poaching' of medical professionals from countries which face far more serious health challenges. The Royal College of Nursing (RCN), while supporting the right of individual nurses to travel and work abroad, has condemned the "systematic depletion of other countries' nursing workforces to address UK shortages". Even in developing countries which may not suffer their own nursing shortages, the RCN notes, it is often the most skilled and experienced nurses who are recruited to work abroad, to the obvious detriment of their home systems.

Some middle-income countries have tried to mitigate the effects of this brain drain by

recruiting medical personnel from other countries in their turn. Jamaica has turned to countries such as Ghana, Nigeria and Myanmar to offset its shortages; South Africa has brought in doctors from neighbouring states and from Cuba. However, this simply leaves the poorest countries to bear the brunt of the problem, since they have nowhere else to turn for replacement personnel.

Increased trade in health services risks exacerbating this transfer of medical personnel from poor to rich countries, thereby placing an even greater strain on health systems in the poorest. Since these are often the countries with the most acute health crises, the public health consequences of expanded trade can be considerable. Weighed against these losses, the remittances which medical personnel send home, and the enhanced skills they bring with them when (and if) they return, are poor compensation.

2.2 Trade in water and sanitation

In addition to trade in health care, trade in water and sanitation services also raises significant issues for children's right to health. While cross-border supply of water has been mooted between resource-rich and resource-poor areas (e.g. from Canada to California), trade in water and sanitation services essentially means the commercial presence of foreign corporations. Here at least there are no balance of payment incentives encouraging developing countries to engage in increased trade: almost all the transnational corporations in the water and sanitation sectors are European, and none are from the developing world.

Clean water and proper sanitation facilities play a particularly important role in maintaining health during infancy and early childhood. Yet 1.1 billion people across the developing world still lack access to safe drinking water, and 2.4 billion people – two fifths of the world's population – do not have adequate sanitation. As a result, more than two million children die from sanitation-related diseases every year, while millions more suffer from health hazards such as schistosomiasis and intestinal worms (WHO and UNICEF 2000).

Access to water and sanitation facilities varies greatly according to both social environment and socioeconomic status. Rural populations are disadvantaged relative to urban in all parts of the developing world, with only 47 per cent of rural households enjoying access to an improved water supply in Africa, 62 per cent in Latin America and the Caribbean, and 75 per cent in Asia. In the case of sanitation the picture is worse still, with rural coverage at 45 per cent in Africa, 49 per cent in Latin America and the Caribbean, and just 31 per cent in Asia (WHO and UNICEF 2000). Even these aggregate figures fail to capture the true extent of non-coverage in many poorer communities: in six countries examined by the World Bank's Living Standards Measurement Study, 80 to 90 per cent of the rural poor have no sanitation facilities of any kind (Komives et al. 2001).[13]

As with health care, commercialisation has further restricted poor families' access to water and sanitation in many parts of the world. Cost recovery and water privatisation schemes have typically involved significant price rises, often putting water beyond the reach of low-income

households. In Ghana, for example, where the World Bank has made water privatisation one of the conditions which will trigger hundreds of millions of dollars in additional loans, even water tariffs which the government and the Bank consider to be below the market rate are beyond the means of most families (ISODEC and GCI 2001).

Such developments raise similar problems of equity to those encountered in health care – except that with water, as with education, demand for the service is continual, not intermittent. This ongoing need means that low-income families in the Mauritanian capital Nouakchott now have to spend up to a fifth of household budgets on water alone (World Bank 2000a). Where households are unable to sustain this level of expenditure, children are often exposed to health risks from water collected from rivers or other untreated sources.

Given the low levels of coverage afforded to poor sections of the population by existing water and sanitation systems, the private sector has often been invoked as a necessary remedy for failing public systems. The IMF and World Bank continue to press developing countries to introduce water privatisation or full cost recovery programmes, often in the face of massive popular opposition. A review of IMF loan agreements across 40 countries during 2000 has revealed that water privatisation or full cost recovery was a condition in 12 of them (Hennig 2001).

Yet privatisation of water delivery offers no ready solution to problems of access by low-income households. As with health care privatisation, the prospect of cream skimming by private companies (or 'balkanisation') leaves poor households excluded or dependent on a public sector alternative which is no longer financially viable:

> *A key consideration from a rights perspective is whether privatisation can ensure access by all to at least basic levels of services in a non-discriminatory manner; or whether privatisation will lead to a balkanization of the market with the profitable sectors being passed into the hands of private shareholders, and the poor and marginalised groups being forced to purchase water at much higher rates than in the privatized sector – or left to the state, which having lost the profitable sector to cross-subsidize the disadvantaged segments of society, finds it increasingly difficult to finance the provision of services to marginalised groups.* (Nigam and Rasheed 1998)

This inherent conflict between profit motives and public service goals has already shown itself in practice. Several concessions have been awarded to private sector water companies with strict targets for expanding access for poor families, but the planned connections have typically failed to materialise. In December 1999, UK water company Biwater actually withdrew from negotiations over water services in Zimbabwe when it became clear that local residents would not be able to afford water at a price which would bring the company the desired returns (Bayliss 2000).

Under privatisation, rising prices have often been accompanied by falling quality. In 1995 Puerto Rico contracted management of its water

authority to the world's largest transnational water corporation, French company Vivendi (then Générale des Eaux). Four years later, an official report condemned the contract for failing on all fronts, with many customers complaining that their water supply had deteriorated dramatically – although they still regularly received their bills on time. Similar problems have been recorded in several other countries, such as Argentina, where a Vivendi subsidiary obtained a 30-year concession to supply the province of Tucuman. While water tariffs doubled, the company failed to deliver the planned investment programme and the water went brown (Hall 2001b).

Water distribution is one of the few service sectors not listed in the GATS sectoral classification list (sewage and sanitation services are included under 'environmental services'). In view of the fact that all the world's major water transnationals are based in Europe, the EU has called for a new classification of 'environmental services' to include water collection, purification and distribution services, as well as waste water services (European Communities 2000).

The guidelines adopted for the GATS 2000 negotiations in March 2001 state that there shall be no *a priori* exclusion of any service sector or mode of supply, so the EU can engage other countries in debate over water liberalisation as of now. However, it may need to achieve general agreement on a modification of the sectoral classification list if countries are to be able to make the relevant market access or national treatment commitments in their national schedules.

2.3 Balance sheet: meagre gains, high risks

GATS aims to increase global trade in services as a result of progressive liberalisation. As this chapter has outlined, an increase in trade in health services offers a handful of developing countries a limited set of export opportunities, predominantly in attracting foreign consumers to their health facilities (mode 2) and in sending their own health professionals abroad (mode 4).

Yet these gains look trivial when compared with the effects which increased trade in health services could have on children's right to health. While there may be individual cases in which patients benefit from the future development of telemedicine (mode 1), the potential impacts of increased trade in health services are overwhelmingly negative. For developing countries to divert health care resources and personnel towards foreign consumers for the sake of balance of payment gains, whether in their own health facilities or abroad, can only lead to increased pressure on health systems which are in most countries already overstretched.

The attraction of foreign investment into the health, water and sanitation sectors (mode 3) may initially seem a more promising option. Yet the commercial presence of private sector companies is unable to address the central problems of access and quality which challenge health, water and sanitation systems across the world. Instead of adding extra capacity to beleaguered public services, the private sector threatens to undermine them by taking over the most profitable parts of

the system and drawing key personnel away from the public sector. In addition, it threatens to increase existing inequalities, given that the poor are commonly excluded from services provided on a commercial basis.

Trade in health services, then, risks exacerbating many of the problems which already plague systems across the world. In that it is aimed at increasing trade, the main thrust of GATS towards greater liberalisation seems inappropriate for the health sector. In the words of policy advisers from Mozambique's Ministry of Health:

> *Despite the attractiveness of open economic policies in some sectors of the country, in health the damage may outweigh the benefits, particularly for those with little ability to pay more for publicly provided health care.*
> (Pavignani et al. 1998)

3. GATS 2000: market access and national treatment

The introduction of services into international trade negotiations during the Uruguay Round of GATT marked a watershed in the history of global trade. Yet the formulation of the GATS text was seen as no more than a first step towards the liberalisation of international services trade. Under GATS Article XIX, all WTO members are committed to "successive rounds of negotiations… with a view to achieving a progressively higher level of liberalisation", and the first of those rounds – GATS 2000 – is already under way. This chapter examines the specific challenges which GATS liberalisation commitments pose to public health.

After a year of debate on the modalities to be used in the negotiations, the substantial work of GATS 2000 began at the end of March 2001 with the initiation of the 'market access' phase. By means of a 'request-offer' process, countries are required to commit more of their service sectors to liberalisation by allowing market access to foreign service providers and guaranteeing that the same 'national treatment' will be extended to foreign as to domestic providers. While governments can choose not to commit sectors to outside competition, the point of the process is to extend liberalisation into new areas of service delivery. As the European Commission has confirmed, individual countries will come under increasing pressure to engage.

One of the prime sectors targeted for this extended liberalisation is health care. The WTO Secretariat welcomes the fact that GATS 2000 "offers an opportunity for WTO Members to reconsider the breadth and depth of their commitments on health and social services, which are currently trailing behind other large sectors" (WTO 1998). While expenditure on health care accounts for over US$3 trillion a year in OECD countries alone, it contributes comparatively little to international trade. The GATS 2000 negotiations are intended to remedy this perceived failing.

The specific commitments on health made by WTO member states under GATS have also been limited – indeed, during the Uruguay Round the health sector drew fewer commitments than any other except education. Moreover, many of the commitments which have been made remain subject to specific limitations (in additional to the horizontal limitations which apply across all sectors). Of the 39 members which have made commitments under the subsector of hospital services, for example, only nine have commitments unqualified by specific limitations.[14]

The Appendix to this report reproduces the WTO's breakdown of specific commitments in the health sector by country. The table does not register which members have included specific limitations as part of their commitments, for which it is necessary to examine the individual country schedules.[15] Nonetheless, it becomes apparent that certain countries have used GATS to signal their openness to trade and foreign investment in health services: Burundi, Dominican Republic, The Gambia, Hungary, Malawi, Mexico, Poland, Sierra Leone and Zambia stand out in this regard.

The great majority of developing countries, however, have refrained from making any specific commitments within the health sector

under GATS. Not that non-commitment necessarily implies that a country's health services are closed to trade or foreign investment; on the contrary, many have already opened significant areas of their health sector to external competition as a result of liberalisation under structural adjustment programmes, just as several countries which chose to make commitments simply introduced 'standstill bindings' describing the status quo. Nonetheless, the GATS 2000 negotiations have scope to achieve genuine expansion in health service liberalisation and to increase the opportunities for health services trade.

3.1 Liberalisation commitments in health

The specific commitments which countries could make to remove existing barriers to trade in health services differ between modes. In mode 4, for example, there are substantial obstacles to the export of medical personnel from developing countries – indeed, not one WTO member has undertaken full and unlimited commitments under mode 4 in any of the four health subsectors. Most industrialised nations maintain economic needs tests or similar restrictions enabling them to control the number of foreign nationals working in their country.

These restrictions are of particular concern to countries such as India, which has risen in recent years to be the world's leading economy in terms of workers' remittances, with receipts totalling more than US$10 billion in 1997 alone (Butkeviciene 2000). Much of this rise is due to the success of the country's software programming industry: even despite the increased importance of cross-border delivery by electronic means, 60 per cent of India's lucrative software exports still come from programmers working on temporary contracts at the client's site (Chadha 2001).

India has consequently led the call for greater liberalisation of movement of professionals as a specific means of increasing the participation of developing countries in international services trade, as demanded by GATS Article IV. In order to meet these requirements, industrialised countries would need to extend greater recognition to professional qualifications obtained in developing countries, and to include developing countries in the mutual recognition agreements which are commonly restricted to industrialised states. In addition, India has also called for more transparent administration of visa and work permit regimes (India 2000).[16]

Issues of recognition also govern the extent to which developing countries are able to attract foreign medical students to study in their country, as with those German students of traditional Chinese medicine who gain university credits for courses taken in China. Yet a more significant consideration for increasing consumption of health services abroad (mode 2) is the issue of insurance portability. In most countries there are significant constraints on the validity of health insurance for consumption abroad, so that it is only in limited cases that a patient will be covered for treatment under their existing insurance policy.

Those developing countries which aim to make export gains from attracting more foreign consumers to their health facilities would benefit from an expansion of health insurance portability. The consideration is particularly significant in the case of older people from industrialised nations who might choose to retire to developing countries if their health insurance allowed them access to medical care there – a potential growth area for countries such as Morocco, Tunisia and Mexico, all of which offer attractive climates on the doorstep of industrialised states. Unlike the deliberate restrictions on movement of natural persons to their territories (mode 4), few countries seek to restrict their own citizens from travelling to take advantage of health services abroad if they are willing to pay for those services themselves. However, recent controversy over National Health Service patients in the UK being sent abroad for treatment in other European countries' hospitals indicates the political sensitivity of channelling public health finances towards foreign health systems.

Under both mode 2 and mode 4 of GATS, developing countries require additional commitments from other states if they are to to expand their trade in health services, given that their chief (economic) interest here relates to their own exports. Under modes 1 and 3, where their chief interest is in imports from industrialised nations, developing countries control the level of liberalisation themselves. While there is little understanding of what liberalisation commitments under mode 1 might entail (so that many countries have explicitly left the telemedicine sector unbound for technical reasons), commitments under mode 3 are of central importance to the future development of a country's health service.

In particular, liberalisation of a country's domestic health system is the mechanism by which transnational health service corporations gain access to previously closed markets. The powerful US Coalition of Service Industries (CSI), which has largely informed the US government's negotiating position on GATS, has identified the GATS 2000 negotiations as the key to its goal of "market access and national treatment commitments allowing provisions of all health care services cross border" (CSI 1999).

The CSI acknowledges the market potential of some developing countries "as newly emerging middle classes demand the levels of health care previously enjoyed only in more developed economies". Nowhere is this potential more evident than in Latin America, where US insurance companies and investment funds have sought new opportunities as their own domestic health care market has become increasingly saturated. Over the past five years, US managed care schemes in countries across Latin America have posted high returns: Brazil's Sul America Seguros, which was at that time half owned by the giant US health care corporation Aetna, generated revenues of US$1.2 billion in 1996 alone (Stocker et al. 1999).[17]

At the same time, the CSI notes that restrictions on corporate access in the health sector "are by and large not a problem in emerging markets", given the extensive liberalisation which has already taken place in most developing countries over the past two decades. For the private health

care providers of the USA, the glittering prize remains the public health sector in other OECD countries, which have remained substantially closed to private sector competition from foreign corporations. The prospect of public services coming under threat from GATS in this way has roused a storm of protest from countries which value the public provision of basic services such as health and education.

3.2 GATS and public services

In the face of this protest, the WTO has repeatedly insisted that countries can protect their public health sector from GATS by virtue of Article I:3b, which defines the services covered by GATS as "any service in any sector except services supplied in the exercise of governmental authority". This clause exempts such services from even the general GATS disciplines of most favoured nation and transparency obligations.

However, Article I:3c, following immediately after the above, defines a 'service supplied in the exercise of governmental authority' as "any service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers". This restrictive definition undermines the exemption which public services might seem to enjoy from GATS in the large number of countries where private and public health service providers compete for patients. Indeed, the WTO's own analysis of GATS in relation to the health sector specifically questioned the exemption of public health services in countries where there are private and public operators:

> *It seems unrealistic in such cases to argue for continued application of Article I:3 and/or maintain that no competitive relationship exists between the two groups of suppliers or services.* (WTO 1998)[18]

In addition, the WTO has also questioned whether those public services which are provided in the absence of any competitive relationship with the private sector fall under the exemption of Article I:3b, if they can be seen to be provided on a commercial basis. Examples given by the WTO include cases where a government charges patients or their insurance company for the treatment provided, or where it provides supplementary subsidies for social or regional policy purposes. Again, this would disqualify the service from exemption from GATS.

Interestingly for governments which have embraced build-operate-transfer (BOT) partnerships with the private sector, the WTO's analysis suggested these would be viewed not as public services but as government-regulated commercial ventures or as examples of government procurement, depending on the rights conferred. In the former instance, the WTO argued, the services would not qualify for exemption under Article I:3b.

In the latter case the schemes would fall under Article XIII of GATS, which exempts government procurement from most favoured nation, market access and national treatment requirements, so long as the services purchased are not for commercial resale. However, government procurement of services will eventually be dependent upon the outcome of current

negotiations within the Working Party on GATS Rules, as prescribed by Article XIII:2. Given the high importance of government control over its procurement of services, both for domestic development purposes and in order to guarantee that those services are delivered in full accord with public service objectives, it is crucial that states retain full powers to direct such procurements in line with their own national development goals.[19]

In the face of international protest, the WTO has now suggested action to remove the threat to public services from the text of GATS:

> *[I]f it were thought desirable… to take further steps to make it clear that the liberalization of services trade is not a threat to the autonomy of governmental services, it would be possible to use the opportunity provided by the new round to make it clear that the co-existence of governmental and private services in the same industry does not mean that they are in competition in the sense of Article I:3c and therefore does not invalidate the exclusion from the GATS of the public sector.* (WTO 2001)

It would indeed be desirable to provide such a clarification, and to strengthen Article I:3b further so as to offer broader protection to public services (see recommendations in chapter 5, below). Yet even if GATS Article I:3 is amended so as to exclude the inherent threat to public services from the text of the Agreement, there remains the equal challenge of the GATS 2000 negotiations. As noted above, these negotiations are designed precisely to examine the potential for commercialisation of each country's service sectors, and governments will come under increasing pressure to commit more of their public services to liberalisation under the market access and national treatment provisions of GATS. As the Coalition of Service Industries reminded the US Trade Representative prior to the start of the GATS 2000 negotiations:

> *Contestable markets in every sector and in every WTO member is the ultimate goal.* (CSI 1999)

3.3 Market access

Under the GATS 2000 negotiations, countries are to commit their service sectors to liberalisation but may register specific limitations on market access in their national schedules. These limitations represent quantitative restrictions on the market. Where a sector has been committed and no such limitations have been registered, market access restrictions are prohibited under GATS.

GATS Article XVI lists six categories of prohibited limitations: (a) on the number of service suppliers; (b) on the total value of transactions or assets; (c) on the number of service operations or quantity of service output; (d) on the total number of natural persons employed; (e) on the type of legal entity through which a service provider may supply a service, such as joint venture requirements; and (f) on the level of foreign shareholding or foreign investment.[20] In the latter two categories, Article XVI represents a significant erosion of national sovereignty over the type of foreign investment a country attracts into its service sectors – far greater than the

prohibition of local content and trade balancing requirements included within the WTO's TRIMS Agreement, which covers investment measures relating to trade in goods.

The relevance of such quantitative restrictions to the quality of services may not be immediately apparent. Yet one example of their interrelation is highly topical. Amidst the international outcry over the TRIPS Agreement and developing countries' access to generic drugs, little attention has been paid to the parallel threat under GATS Article XVI. Countries which commit their health sectors to increased liberalisation could risk challenge before a WTO disputes settlement panel if their public health policies impose market access restrictions on brand-name pharmaceuticals, even on public health grounds.

Mozambique, for example, has largely protected its public health sector from the negative effects of pharmaceutical companies' sales promotions by means of a national formulary (of around 400 essential medicines) and the mandatory use of generic names for all drugs, along with therapeutic guidelines from the Ministry of Health and restrictions on the number of health personnel licensed to prescribe certain medicines (Pavignani et al. 1998). Were Mozambique to commit its paramedical sector to full market access in its national schedule (as neighbouring Zambia has done), its pharmaceutical policy could be challenged on the grounds that it had imposed a quantitative restriction on the market itself – just as Canada's attempt to promote the prescription of drugs by generic rather than brand names was successfully challenged under NAFTA market access rules (PSI 1999).

Similarly, public health regulations governing the marketing of breast-milk substitutes could be seen as market access limitations under GATS. Many countries have incorporated WHO's International Code of Marketing of Breast-milk Substitutes into their national legislation as a central plank in child health promotion strategies; Article 5 of that Code is specifically designed to restrict advertising and marketing of breast-milk substitutes. With national legislation which incorporated such restrictions, any country which committed its advertising sector to liberalisation under GATS (as countries such as Burundi, Jamaica and The Gambia have done) and did not enter specific limitations exempting the marketing of breast-milk substitutes (as none of those countries have done) could be challenged on grounds of contravening Article XVI.[21]

3.4 National treatment

National treatment refers not to quantitative restrictions of the market as a whole, but to the qualitative treatment of foreign service suppliers within it. The principle requires a government to extend treatment to foreign service suppliers that is "no less favourable" than the treatment it extends to its own domestic suppliers. Limitations of national treatment, therefore, are measures by which a government discriminates in favour of domestic suppliers, for such reasons as national development policy, the environment or public health.

The introduction of the national treatment standard in GATS Article XVII marked its first appearance in a multilateral investment

agreement. For the transnational corporations which had lobbied for years to see its incorporation, inclusion of national treatment in GATS was a major breakthrough. Indeed, GATS remains the model for the multilateral agreement on investment which the EU seeks to negotiate at the WTO (Lamy 2001).

As with GATS rules on market access, however, the national treatment standard threatens to undermine central public health objectives. The WTO has provided a first example of how this might work in practice. In its analysis of health and social services, the WTO suggests that state subsidies and other economic benefits provided to public sector hospitals would fall under the remit of GATS Article XVII (WTO 1998). This means that any government which had committed its public health sector to liberalisation under GATS would be required to provide similar funding to private sector hospitals, unless it had also entered specific limitations in its national schedule to exempt funding of public sector hospitals from national treatment commitments. As a result the government would be left with the invidious choice of channelling large amounts of public sector finances to the private sector or abandoning its public health institutions to the market.

Other subsidies are directly targeted at promoting children's right to health. In view of the negative impact of user fees on access to health care, many developing countries have introduced exemption schemes for poor and marginalised families. While these have largely been unsuccessful in protecting the most vulnerable households, in cases such as Kenya – where all children up to the age of 15 are officially exempted from consultation fees – the schemes have gone some way towards mitigating the full impact of cost recovery programmes on children.

Yet user fee exemptions could also be challenged as trade-distorting subsidies under the national treatment standard. Again, it would be up to individual countries to specify these exemptions as limitations to their national treatment commitments, or else be faced with the unenviable political dilemma of either dropping the exemptions or providing similar subsidies to the private sector out of public funds. The USA has foreseen precisely such challenges to its own subsidy programmes: its schedule of specific commitments explicitly protects subsidies at federal, state or local level which extend preferential treatment to members of "socially or economically disadvantaged groups".

Staff from the WTO's Trade in Services Division confirm that this limitation on national treatment in favour of economically disadvantaged groups or regions is:

> *a potentially powerful instrument for developing countries to reconcile trade with social equity objectives* (Adlung and Carzaniga 2001).

Yet the whole thrust of GATS is to move towards progressive liberalisation of services by removing such limitations. The GATS 2000 negotiations represent the start of this process, but, as noted at the beginning of this chapter, GATS Article XIX commits WTO members to "successive rounds of negotiations… with a view to achieving a progressively higher level of liberalisation". In this ongoing process, governments will find themselves

under increasing pressure to drop their limitations to national treatment. As they do so, they will lose the ability to direct their national health and development policies in favour of those who need them most.

In the above examples it should be pointed out that there need be no explicit intention to discriminate against foreign service providers (as exists, say, in the economic needs tests which specifically restrict the ability of foreign professionals to provide services within a particular market). Crucially, the national treatment standard refers to *de facto* as well as *de jure* discrimination: if the situation resulting from a particular national policy can be interpreted as offering domestic suppliers an advantage over foreign competitors, the standard has been violated.

It should also be noted that the health implications of the national treatment standard extend beyond the health care sector itself. One of the key elements behind the public health achievements of the Indian state of Kerala, for example, is the successful provision of essential food items through the subsidised public distribution system, which covers 96 per cent of the state's population (Thankappan 2001). Once again, such subsidies would fall foul of GATS national treatment rules, even though abandoning the policy could have damaging effects on Kerala's laudable infant and under-5 mortality rates.[22]

3.5 GATS 'lock-in'

WTO staff members concede that it is difficult to foresee which elements of national legislation might clash with market access or national treatment commitments. Yet once a country has scheduled such commitments, it is effectively impossible to go back on them. Under GATS Article XXI, any country wishing to modify its schedule of commitments – whether by restoring old limitations or adopting new ones – can only do so a full three years after the date at which the commitment entered into force. It must then give three months' notice of intent before introducing the change, and then (more importantly) can be challenged to provide acceptable compensation to other WTO member states before any modification may be introduced.

This 'lock-in' feature has the effect, in the words of David Hartridge, former Director of the WTO's Trade in Services Division, of making GATS commitments "irreversible". While tariff bindings are also supposed to be irreversible under agreements governing trade in goods, there is little understanding of the long-term consequences of liberalisation in health services trade, or even a basic agreement on how to measure its impact. The result is that countries are now being pressured to make extensive liberalisation commitments without knowing how these might clash with their own national legislation in future – and with little practicable chance of retracting the commitments if they turn out to do so.

Pro-liberalisation commentators see this "pre-committing to a future reform path" as an important component of GATS, and one which

will play a key role in the current negotiating round (Hoekman 1999). Yet in terms of public health objectives, this denial of flexibility could prove disastrous. The negative impacts of user fees introduced under structural adjustment have demonstrated the need to reverse cost recovery programmes and to restore universal access to basic health care free at the point of delivery. Under GATS such reversals would prove immensely difficult, as market access and national treatment commitments would be locked in.

Even when governments have been unwilling to reverse their decisions, public opposition has won back control of privatised services. In the celebrated case of Cochabamba, Bolivia, sale of the city's water system to a subsidiary of US transnational Bechtel led to price increases of at least 35 per cent. Mass demonstrations and strike action were met with military force, with one person killed and hundreds injured; faced with the prospect of increasing bloodshed, the government eventually backed down and restored public ownership of the water supply. Had Bolivia committed its water distribution system to liberalisation under GATS (as would be possible under the EU's proposed classification system), such a reversal would have been open to challenge from other WTO members, placing increased pressure on the government to resist a political solution and continue with the military option (Gould and Joy 2000).

Perhaps the most sinister aspect of GATS is that the WTO has actively promoted it as a weapon to be used by governments against democratic protest. The question and answer guide to GATS posted on the WTO's website recommended GATS to pro-liberalisation governments for the political assistance it can bring them in "overcoming domestic resistance to change". Clearly embarrassed when it was revealed to be promoting GATS as an anti-democratic device, the WTO has now removed the offending text from its website.[23] The underlying reality, however, remains the same.

GATS does allow countries to introduce measures which conflict with its disciplines on exceptional grounds such as public health, public morals and public order (Article XIV). However, such exceptions have in the past proved very weak in the face of challenge before a disputes settlement panel, as illustrated by the GATT Thai tobacco case described in the next chapter. The WTO's mandate of promoting trade liberalisation means that its disputes panels view public health provisions in WTO agreements in terms of their impact on trade, not their contribution to non-commercial objectives. As WHO officials have affirmed:

> *[I]t should not be assumed that the governing bodies of WTO will ensure that these provisions are upheld for legitimate public health reasons.* (Bettcher et al. 2000)

Negotiations on whether to include emergency safeguard measures within GATS, as there are in GATT Article XIX, are continuing within the WTO Working Party on GATS Rules. If such measures are to be included (which is still under debate), they could be invoked in exceptional circumstances to save a domestic industry from economic collapse. They would not normally apply on grounds of public health (WTO 2001).

4. GATS and domestic regulation

The increased commercialisation of the health sector puts extra pressure on systems which are often already under severe strain. As with other basic services, it is widely acknowledged that there needs to be strong and effective regulation of private sector providers if sectoral objectives are not to be undermined. Yet regulatory frameworks are of particular importance in health care, to protect patients from unsafe medical practices, to clamp down on excessive charging by unscrupulous suppliers, and to ensure that public health policies take precedence over the corporate interests of the private sector.

Developing countries have long faced difficulties in enforcing such regulation, particularly in the context of decentralisation of health care, where local authorities have even less capacity than central government to supervise service providers. WHO has highlighted the systemic nature of this problem throughout the developing world, given the high transaction costs which regulatory oversight and contractual strategies entail. Despite official awareness of the need for regulation, in many countries the growth of the private sector has outstripped government capacity for control (WHO 2000a).

National surveys indicate the extent of the problem. One study from Malawi revealed that almost three in four private practitioners were flouting the government's minimum quality standards for equipment and drug use. A programme of inspection of 6,700 pharmacies in Punjab, Pakistan, led to the immediate closure of 590 on quality grounds, with cases registered against a further 1,738. Yet a separate intervention in Pakistan demonstrates the difficulties faced by overstretched regulatory authorities in many parts of the developing world: following a series of infant fatalities related to paediatric Imodium, a ban on the drug led to its withdrawal from nearly all retail outlets but its continued sale on the black market (Smith et al. 2001).

Similar challenges apply to private sector involvement in health insurance, exacerbated by the fact that regulation is generally much weaker here than in other insurance sectors. This widespread failing "makes it easier for health insurers to engage in fraud, unfair competitive practices, or other practices harmful to consumers or contrary to national health objectives" (Lipson 2001).

In many cases, lack of regulatory capacity may simply be down to limited resources. The situation is compounded, however, when private sector companies actively subvert the system through 'regulatory capture': the co-opting of regulatory systems and the personnel responsible for them so that the regulations are relaxed or not applied. Given the power and resources of many private sector health providers – particularly transnational corporations – this threat of subversion remains a major challenge for regulators in the developing world.[24]

For poor families seeking health care, the absence of effective regulation has created an obstacle as serious as their inability to pay for treatment. The problem is particularly acute in Africa, where regulatory systems have all but broken down and patients are often left at the mercy of an uncontrolled market:

> *While some may still travel a long distance to reach any form of health facility, others confront a bewildering variety of public and private health providers and drug suppliers… Users find it difficult to assess the competence of different practitioners, many of whom have had relatively little training. They do not have access to reliable advice on the most cost-effective way to deal with particular health problems and frequently have to rely on their own judgement. What little money they have available is thus often wasted on inappropriate and unnecessary treatment.* (Bloom and Lucas 2000)

WHO has warned that this scenario is a general consequence of the uncontrolled involvement of the private sector in the provision of health care.[25] Moreover, the problem can be exacerbated if the private companies concerned are transnational corporations, many of which have a poor track record when it comes to respecting the national regulations of host countries.[26] The prospect of increased foreign presence in the health sector makes effective domestic regulation by governments more important than ever.

4.1 The 'necessity test'

The WTO has repeatedly argued that GATS does not remove a government's right to regulate services in its country or to introduce new regulations in the future – indeed, the preamble to GATS acknowledges "the particular need of developing countries to exercise this right". However, GATS Article VI:4 mandates the WTO's Council for Trade in Services to develop disciplines which ensure domestic regulations "do not constitute unnecessary barriers to trade in services". As a result, the WTO Working Party on Domestic Regulation has been exploring the concept of a 'necessity test' to determine whether a given regulation might be open to challenge under GATS rules.

The central requirement of the necessity test is outlined in GATS VI:4b, namely that any government regulation of a service should be "not more burdensome than necessary to ensure the quality of the service". In keeping with the necessity tests included within other WTO Agreements (notably the Agreement on Technical Barriers to Trade and the Agreement on the Application of Sanitary and Phytosanitary Measures), the test would demand that the government in question prove its regulation to be the least trade-restrictive measure possible to achieve the desired result.

As it stands, this requirement issues an open challenge to all regulation by shifting the burden of proof onto the regulating government, not the service provider. Moreover, the requirement that any regulation be shown to be the least trade-restrictive possible threatens to conflict with the primary aims of public health policy, and in particular with children's rights. Under Article 24.1 of the Convention on the Rights of the Child, children are entitled to "the highest attainable standard of health". Yet GATS VI:4 requires that government regulation should minimise restrictions on trade, not maximise health opportunities, even when – as the WTO itself acknowledges (WTO 1999b) – those two objectives can conflict with one another.[27]

The EU has also acknowledged the conflict between degree of trade restriction and a country's regulatory ability, arguing against the use of 'least trade-restrictive' as a standard within the necessity test on the grounds that it would "unduly restrict the choice of the regulatory tools available" (European Communities 2001). Instead, the EU has introduced the concept of 'proportionality' to the necessity test, whereby a regulatory measure would not be considered more trade-restrictive than necessary if it were not 'disproportionate' to the objective pursued. Yet this simply begs the question in the same way as Article VI:4b does: any necessity test which examines a regulation's degree of trade-restrictiveness threatens to compromise regulatory capacity, even if the regulatory objective is taken as valid.

One manifestation of the necessity test's influence can already be seen in the trend towards use of market mechanisms rather than statutory powers to regulate in favour of public health. Instead of compulsory regulation, the pressure to employ less trade-restrictive measures has led to greater use of consumer mechanisms, where responsibility is left to the individual, not society as a whole:

> *In the case of health or public health concerns there seems to be pressure to use labelling in contrast to other more systematic regulatory mechanisms (e.g. taxation, banning of access, advertising or use). Thus a general concern is that a general bias towards individualised regulatory measures and shifting of risks (financial and other) from corporations to public sector and individuals may well be indicated, with subsequent redistributive implications.*
> (Koivusalo 1999)

In the context of infant health, to take one example, the trend away from statutory regulation would undermine the International Code of Marketing of Breast-milk Substitutes. While consumer mechanisms alone would clearly be less trade-restrictive than national legislation incorporating the Code, they would also expose infants to new levels of risk. As noted above, it must be remembered that the WTO disputes settlement panels which rule on these issues do so on the basis of trade considerations, not public health concerns.

A pre-WTO disputes settlement ruling shows how the necessity test works in practice. In 1990 the US government, on behalf of its powerful tobacco lobby, called for a GATT disputes panel to examine Thailand's longstanding ban on tobacco imports, one of a range of measures which that country had adopted on public health grounds to tackle the problem of smoking. The Thai government argued that the ban was permitted under GATT Article XX(b),[28] which allows governments to take measures necessary to protect public health, and that it was indeed 'necessary' because allowing imported cigarettes would lead to an increase in cigarette advertising and therefore greater pressure on people – especially young people – to smoke.

WHO contributed evidence from other countries in Asia and in Latin America to show that the liberalisation of closed cigarette markets dominated by a state tobacco monopoly resulted in an increase in smoking among the population. According to WHO, public health programmes are unable to compete with the marketing budgets of the world's most powerful tobacco companies,

and as a result cigarette consumption increases. In the Thai case, WHO noted that the presence of foreign brands and advertising would have a particularly harmful impact on young people and women, who smoked Thai cigarettes far less than adult men.

The GATT disputes panel agreed that smoking was a legitimate public health issue and thus fell within the scope of GATT XX(b). The issue turned on whether the import ban could be said to be 'necessary' – defined as meaning that there was no alternative measure which would be 'less inconsistent' with the trade liberalisation regime of GATT. In the end, the panel upheld the US argument that the Thai government's ban could not be considered 'necessary', given that there were other policies which might also work towards curbing the number of smokers (GATT 1990).

The importance of this GATT ruling was amply demonstrated in one of the WTO's first dispute judgements, which cited it as precedent. In the case brought by Venezuela and Brazil against the USA's Clean Air Act, the WTO's disputes settlement panel acknowledged that the US policy to reduce air pollution from petrol was of relevance to public health and therefore fell within the scope of GATT XX(b). As with the Thai tobacco ruling, however, the WTO panel found that the Clean Air Act's measures to control air pollution did not qualify as 'necessary'. As the party invoking the exemption under GATT XX(b), the onus fell on the USA to prove that the Act's objectives could not have been achieved by other measures less inconsistent with GATT. The panel concluded that it had failed to do so (WTO 1996).

4.2 Threat to cross-subsidisation

Domestic regulation as understood in the context of world trade rules is primarily market regulation; deregulation, correspondingly, refers to the removal of restrictions on competition represented by local monopolies or domestic cartels. Yet Article VI:4 of GATS mandates the WTO Council for Trade in Services to develop disciplines relating to qualification procedures, technical standards and licensing requirements, to ensure that these aspects of service regulation do not constitute "unnecessary barriers to trade". By this means, as the above examples indicate, GATS expands the purview of domestic regulation to include not just regulation of the market but regulation of the services themselves.

Yet pressure on market regulation poses its own threats to public service provision. As noted, current negotiations within the WTO Working Party on Domestic Regulation aim to develop the necessity test as a means of examining whether a country's service regulations are "not more burdensome than necessary". There are concerns that the WTO and EU are trying to incorporate 'pro-competitive' principles into the disciplines on domestic regulation which would require service charges to be cost-oriented and 'unbundled' if they are to be identified as necessary, thereby undermining the possibility of using cross-subsidy in order to ensure universal access to services (Pollock and Price 2000). This mirrors the *de facto* threat to cross-subsidisation brought by increased private sector involvement in public services, examined in chapter 2.

The importance of cross-subsidisation as a mechanism for developing countries to realise social objectives is widely acknowledged:

> *While there are clearly potential sources of gain for WTO members associated with a set of subsidy disciplines, subsidies will frequently be the most efficient instrument to pursue non-economic objectives – e.g. to ensure universal service; promote regional development; offset income inequalities; and so forth. Cross-subsidies of the type that are often regarded as inefficient and nontransparent mechanisms to achieve an objective may sometimes be the best available second best instruments for developing country governments.* (Hoekman 1999)

Nor is it only in developing countries that cross-subsidisation plays an important role. Even within the context of the UK's privatised water industry, the principle of cross-subsidisation is well established as a means of ensuring universal access, and has recently been extended by special tariffs for low-income families and single households (Waddams Price and Young 2001). Given the benefits of water regulation for society as a whole, including lower health risks and thus reduced health expenditure, any challenge to regulatory mechanisms as a result of GATS domestic regulation disciplines would be highly detrimental (Ugaz 2001).

5. Conclusion and recommendations

The expansion of trade liberalisation poses serious challenges to children's right to health. While some families may benefit from the increased economic opportunities which globalisation brings, many more stand to remain marginalised from its gains. Those communities whose food security is undermined by exposure to international markets are directly at risk from increased trade liberalisation, and measures must be taken – in the context of the Agreement on Agriculture and elsewhere – to protect their livelihoods. As all commentators acknowledge, it is the most vulnerable who are most at risk.

GATS plays a particular role in the expansion of international trade liberalisation, in that it deals directly with the basic services which underpin children's rights. As shown in chapter 2, increased trade in health services offers meagre economic benefits to a handful of developing countries, while diverting resources and personnel towards foreign consumers threatens to put extra pressure on health systems which in many countries are already at breaking point. The commercial presence of transnational health corporations risks exacerbating existing problems of equity, quality and capacity; given the low level of regulatory capacity in many countries, increased foreign investment in the health sector may well be a poisoned chalice.

These conclusions argue against the suitability of the trade liberalisation model for basic services as a whole. For this reason, as stated below, Save the Children supports the international call for a full and independent assessment of GATS and services trade. In view of the effective irreversibility of GATS market access and national treatment commitments, countries should not come under pressure to liberalise their basic services. Developing countries, in particular, should avoid making liberalisation commitments on basic services under GATS.

In addition to this general concern, there are also specific problems related to GATS disciplines on market access, national treatment and domestic regulation, as discussed in chapters 3 and 4. Recommendations on these issues are also included below. While there may be procedural delays in amending GATS, a reassessment of the text should form part of the wider review of WTO agreements called for by developing country governments and civil society organisations around the world.

1. Full and independent impact assessment

Perhaps the most important requirement, in relation to GATS as also to other WTO agreements, is for the international community to step back and assess the impact of trade liberalisation. GATS Article XIX:3 requires the WTO Council for Trade in Services to carry out an assessment of trade in services, both in overall terms and on a sectoral basis, prior to establishing the guidelines for each new round of GATS negotiations. The background notes published by the WTO in 1997 and 1998 do not address the consequences of services trade, and no further commitments to liberalisation should be made until such an assessment has been carried out.[29]

Save the Children supports the call for a full and independent impact assessment of GATS and services trade liberalisation. Such an assessment should take into account the potential impacts of services trade liberalisation on different sectors of society, not just on national economies as a whole. Particular attention must be paid to the effects of services trade liberalisation on children, given that their rights are often at most risk of violation when public services are compromised.

This assessment could make use of the report on the human rights implications of liberalisation of trade in services which the UN Sub-Commission on Human Rights requested at its 53rd session in August 2001 (resolution 2001/4). That report, which is to focus particularly on liberalisation in the framework of GATS, is due to be presented to the Sub-Commission's 54th session in 2002. The same resolution calls on other relevant UN agencies to undertake research into the impact of GATS on basic services, and recommends that any WTO assessments of GATS take into account the findings of UN analysis.

2. National sovereignty over liberalisation commitments

Countries must be allowed to exercise national sovereignty over their own policy objectives in relation to health and development. This includes the right to reverse liberalisation measures once they have been adopted in national schedules of specific commitments. Under GATS Article XXI, the penalties for such reversals are far too punitive, making market access and national treatment commitments effectively irreversible. This constitutes an unwarranted transfer of risk from the private sector to the general public, including children.

Save the Children believes that countries must be guaranteed the right to make their own decisions regarding development of their service sectors, including whether or not they wish to limit market access and national treatment commitments in future. Article XXI of GATS curtails this right, and should be amended to restore due balance between private and public risk. In addition, as affirmed by GATS Article XIX:2, developing countries must not be pressured to commit service sectors to liberalisation where this does not accord with their own development situation.

3. Stronger exemption for public services

Following the WTO's own suggestion, the text of GATS Article I:3 should be amended to strengthen the exemption of services provided in the exercise of governmental authority. The most effective way to achieve this would be to delete Article I:3c, which restricts the exemption of public services guaranteed under Article I:3b, or to reword it so that 'services provided in the exercise of governmental authority' are understood in relation to function, not means of delivery.

Save the Children believes that Article I:3c of GATS undermines the important exemption of services provided in the exercise of governmental

authority from the provisions of GATS, and that it should not appear in the text in its present form.

4. Removal of the necessity test

The requirement of GATS Article VI:4b that government regulation of a service should be "not more burdensome than necessary to ensure the quality of the service" places undue restriction on domestic regulation. By limiting government regulation according to its impact on trade, whether through the requirement that it be the least trade-restrictive possible or that it be 'not disproportionate' to its objective, the necessity test currently being discussed by the Working Party on Domestic Regulation would undermine a country's ability to regulate its service sectors. If they are to work for the benefit of children and other members of the public, the domestic regulation disciplines currently being developed by the Working Party must state the clear precedence of human rights over commercial considerations (Howse and Mutua 2000).

Save the Children believes that GATS Article VI:4b and the necessity test current being examined by the WTO's Working Party on Domestic Regulation unduly restrict a country's ability to regulate its own service sectors. Article VI:4b should be deleted from the text of GATS and the Working Party should abandon the necessity test in developing its disciplines on domestic regulation. The Working Party should explicitly recognise a country's overriding duty under human rights law to work for the highest attainable standard of rights for all its people, including its children.

5. Exemption of subsidies from the national treatment standard

The inclusion of subsidies under GATS national treatment rules threatens many key elements of countries' social policy strategies, especially since the national treatment standard in GATS applies to non-protectionist subsidies and *de facto* discrimination as well as subsidies established explicitly in favour of domestic service providers. Article III.8(b) of GATT exempts subsidies for domestic producers from the national treatment standard.[30] The Working Party on GATS Rules, which is currently examining possible disciplines on those subsidies which "may have trade-distortive effects", should move instead to incorporate a similar exemption within the text of GATS.

Save the Children believes that subsidy programmes for domestic service providers are an important tool in the implementation of countries' development and social policies, and should not be jeopardised by GATS national treatment rules. The Working Party on GATS Rules should acknowledge a country's right to use subsidy programmes in the pursuit of social and developmental goals, and should recommend an exemption of subsidies within the text of GATS.

6. Special measures to promote services exports from developing countries

GATS Article IV commits WTO member states to work for the increasing participation of developing countries in international services trade. There is a pronounced asymmetry between the liberalisation commitments already made in relation to the mobility of capital and those made in relation to the mobility of labour. To address this imbalance, industrialised nations should increase their commitments to promote services trade under mode 4 of GATS.

However, given the negative effects of directing medical resources towards economic rather than public health objectives, countries should not seek to make balance of payment gains through trade in health services where there is any possibility of this compromising their domestic health service delivery. The loss of health professionals to cater for foreign consumers threatens to undermine still further national health systems in the poorest parts of the world. All developing country governments should undertake to put public health needs before health sector export opportunities.

Save the Children believes that industrialised countries should promote developing countries' participation in international services trade through increased commitments under GATS mode 4, as well as through greater transparency in their application of economic needs tests, work permits and visa regimes. At the same time, all countries must acknowledge their overriding responsibility to promote the highest attainable standard of public health, especially that of children, and must refrain from diverting health service resources towards economic ends.

7. Funding of basic services

The call for increased trade in health services, and in particular the increased involvement of the private sector, is partly based on the shortage of funding available from other sources. As a corollary to a more considered approach to services trade liberalisation, the international community should realise its repeated commitment to sufficient funding of basic services. The UN's 20/20 Initiative remains an important mechanism for directing a higher proportion of existing resources towards basic services: if all donor countries devoted 20 per cent of their aid budgets to basic services, and all governments did the same with their domestic expenditure, they would be able to meet the US$90 billion global shortfall in public spending on basic services highlighted by Kofi Annan in his end-decade report to the UN Special Session on Children.

Save the Children calls on all governments to work towards sufficient funding of basic services in all countries, including realisation of their commitment to the 20/20 Initiative. Donor countries should also make genuine moves towards the UN target of 0.7 per cent of GNP for official development assistance. Given the predominant importance of domestic resource

mobilisation for investment in basic services and the continuing drain of debt repayment on many developing countries' resources, Save the Children calls on bilateral and multilateral creditors, in particular the World Bank and IMF, to engage in substantial debt cancellation over and above the enhanced Heavily Indebted Poor Countries (HIPC) initiative as a matter of urgent priority.

Appendix: WTO members making specific GATS commitments in the health sector

	HEALTH RELATED AND SOCIAL SERVICES				PROFESSIONAL SERVICES		HEALTH INSURANCE
	Hospital services	**Social services**	**Other human health services**	**Other**	**Medical and dental services**	**Services provided by midwives, nurses and physio-therapists**	
Antigua & Barbuda					✔		
Argentina							✔
Aruba							✔
Australia			✔		✔		✔
Bahrain							✔
Barbados					✔		
Belize			✔		✔		
Bolivia	✔						✔
Botswana					✔	✔	
Brazil							✔
Brunei Darussalam					✔		✔
Bulgaria		✔			✔		
Burundi	✔		✔		✔		
Canada							✔
Chile							✔
Colombia							✔
Congo RP					✔		
Costa Rica	✔				✔		
Cuba							✔
Cyprus							✔
Czech Republic					✔		
Dominican Republic	✔	✔	✔		✔		✔

	HEALTH RELATED AND SOCIAL SERVICES				PROFESSIONAL SERVICES		HEALTH INSURANCE
	Hospital services	**Social services**	**Other human health services**	**Other**	**Medical and dental services**	**Services provided by midwives, nurses and physio-therapists**	
Ecuador	✔						✔
Egypt							✔
European Union (15)	✔	✔			✔	✔	✔
Gabon							✔
Gambia	✔	✔	✔		✔	✔	✔
Ghana							✔
Guinea				✔			
Guyana					✔		✔
Honduras							✔
Hong Kong, China							✔
Hungary	✔	✔	✔	✔	✔		✔
Iceland							✔
India	✔						
Indonesia							✔
Israel							✔
Jamaica	✔				✔	✔	✔
Japan	✔						✔
Kenya							✔
Korea, Republic of							✔
Kuwait	✔	✔	✔				
Lesotho					✔	✔	✔
Liechtenstein							✔

	HEALTH RELATED AND SOCIAL SERVICES				PROFESSIONAL SERVICES		HEALTH INSURANCE
	Hospital services	**Social services**	**Other human health services**	**Other**	**Medical and dental services**	**Services provided by midwives, nurses and physio-therapists**	
Macau, China							✔
Malawi	✔		✔		✔	✔	
Malaysia	✔				✔		✔
Malta							✔
Mauritius							✔
Mexico	✔		✔		✔	✔	✔
Morocco							✔
New Zealand							✔
Nicaragua							✔
Nigeria							✔
Norway					✔	✔	✔
Pakistan	✔				✔		✔
Panama	✔						✔
Paraguay							✔
Peru							✔
Philippines							✔
Poland	✔				✔	✔	✔
Qatar					✔		✔
Romania							✔
Rwanda					✔		
Saint Lucia	✔						
Saint Vincent & Gren	✔						

	HEALTH RELATED AND SOCIAL SERVICES				PROFESSIONAL SERVICES		HEALTH INSURANCE
	Hospital services	**Social services**	**Other human health services**	**Other**	**Medical and dental services**	**Services provided by midwives, nurses and physio-therapists**	
Senegal					✔		✔
Sierra Leone	✔	✔	✔	✔	✔	✔	✔
Singapore					✔		✔
Slovak Republic					✔		✔
Slovenia	✔		✔		✔		✔
Solomon Islands							✔
South Africa					✔	✔	✔
Sri Lanka							✔
Swaziland	✔				✔		
Switzerland					✔		✔
Thailand							✔
Trinidad & Tobago	✔				✔		
Tunisia							✔
Turkey	✔						✔
USA	✔						✔
Venezuela							✔
Zambia	✔		✔		✔	✔	
TOTALS (83 countries)	**41**	**21**	**12**	**3**	**50**	**26**	**78**

Source: WTO (1998), with modifications to include Austria, Finland and Sweden as part of the EU (their accession in 1995 being after the conclusion of the Uruguay Round of GATT); in the totals, the EU states are counted collectively as 15 countries

Notes

1 Annan was due to present the report to the UN General Assembly Special Session on Children in New York from 19 to 21 September 2001. Following the terrorist attacks on the USA of 11 September 2001, the Special Session was postponed.

2 Article 24 of the Convention commits states parties "to ensure the provision of necessary medical assistance and health care to all children", and "to promote and encourage international co-operation with a view to achieving progressively the full realisation of the right recognised in the present article." All but two countries (Somalia and the USA) have ratified the Convention, making it the world's most widely supported human rights treaty.

3 Investment in Angola, predominantly for oil extraction, accounted for 40 per cent of all FDI to least developed countries, leaving just US$2.6 billion for the remaining 47 least developed countries (in 2000) to share between them.

4 "World Bank studies of the impact of the Mexican and Thai financial crises show that, even after the economies of these two countries recovered, health status was still affected. During the transitory but acute recessions, children were taken away from their schools, entered hazardous jobs or prostitution rings, or sustained permanent brain damage if they suffered from acute malnutrition." (Cornia 2001)

5 The relationship between such market changes, household poverty and nutritional status has been extensively demonstrated by Save the Children research; for a recent example, see Gangari et al. (2001).

6 The Zedillo report to the International Conference on Financing for Development, to be held in Monterrey, Mexico, in March 2002, also stresses the importance of domestic investment in basic social programmes such as education, health and nutrition: "These programmes need to have the first call on government resources – they should not be treated as marginal programmes whose budgets can be slashed when times are difficult." (UN Document No. A/55/1000)

7 Details of the process which led to GATS and the subsequent Financial Services Agreement in 1997 reveal the full extent of corporate involvement at the WTO; see Vander Stichele (1998); CEO (1999).

8 WTO officials speculate that trade in health services might well follow Karsenty's general breakdown, though with greater importance for modes 4 and, perhaps, 2 (Adlung and Carzaniga 2001). Much will depend on how the values are calculated, but certainly it would seem that mode 1 has seen far less development than in other sectors. This lack of even the most basic empirical data should signal the need for caution, at the very least, on further liberalisation of health services trade.

9 For details of the inclusion of user fees for health in Poverty Reduction Strategy Papers, see Marcus and Wilkinson (2001). Several countries have announced the intention to develop user fee exemptions in health care, which conforms with stated World Bank policy of supporting the provision of basic health services free to the poor; in the case of Lao PDR, the IMF and World Bank's Joint Staff Assessment encouraged the government to develop such an exemption policy.

10 The WTO Secretariat accepts this tendency: "[P]rivate health insurers competing for members may engage in some form of 'cream skimming', leaving the basic public system, often funded through the general budget, with low-income and high-risk members." (WTO 1998)

11 Similarly, in the case of health insurance: "[E]vidence from countries where private insurers compete indicates that, even with strong regulatory systems, greater competition among health insurers segments and destabilizes the market and undermines the ability to build larger, more equitable risk pools that spread costs between rich and poor, healthy and sick." (Lipson 2001)

12 The figures given are 35,000 in the UK, 60,000 in the USA. This means that there are 0.58 doctors of Indian origin per 1,000 people in the UK, while according to World Bank figures there are only 0.4 doctors per 1,000 people in India itself (World Bank 2000b).

13 The six countries are: Bulgaria, Ecuador, Kazakhstan, Nepal, Nicaragua and Pakistan; almost all households in Bulgaria were reported to have either a sewer connection or a septic tank, making the percentage for non-access in the other countries higher still.

14 These nine are: Burundi, Ecuador, The Gambia, Hungary, Jamaica, Malawi, Saint Lucia, Sierra Leone and Zambia. The Gambia's commitments are, however, subject to horizontal limitations for mode 3 (WTO 1998).

15 Individual country schedules are reproduced online on the European Union's GATS Info-Point (http://gats-info.eu.int) or on the services pages of the WTO's own website (http://www.wto.org). Section 8 of the schedules deals with commitments in health-related and social services, section 7 (financial services) deals with health insurance and section 1 (business services) deals with medical and dental services, as well as services provided by midwives, nurses, physiotherapists and paramedical personnel.

16 Not all developing countries share this enthusiasm for liberalising trade in services through movement of natural persons; South Africa, for instance, which views itself as a target for inward migration, is less keen (Sinclair 2001), as is Malaysia (Gould and Joy 2000). Conversely, the US Coalition of Service Industries has called on the US government to make swifter progress towards an expansion of mode 4 commitments (CSI 2001).

17 Aetna International has since been sold to Netherlands insurance company ING (Hall 2001a). Other European transnationals have also entered the Latin American health care market, with Spanish companies such as Intersanitas, Santander Financial Group and Bilbao Vizcaya Bank leading the way. The World Bank has been instrumental in opening up the Latin American health sector for privatisation, having provided vast loans to 'stimulate' health sector reform in countries such as Mexico and Brazil.

18 Nor was this conclusion an isolated aberration on the part of the WTO: similar doubts were raised as to the applicability of Article I:3c in WTO analyses of other sectors (Krajewski 2001) and by David Hartridge, former Director of the WTO's Trade in Services Division, in an explanatory letter on the issue (Government of British Columbia 2001).

19 Negotiations on government procurement within the Working Party on GATS Rules have made little progress so far, partly because of the parallel work being undertaken by the WTO's Working Group on Transparency in Government Procurement, which covers both goods and services. The WTO's plurilateral Government Procurement Agreement, which now has 26 signatories, may well inform negotiations within the Working Party on GATS Rules (WTO 1995).

20 The WTO's disputes settlement system leaves it to the WTO member challenging a quantitative restriction in another country to identify which type of market access limitation is concerned. This means that, as with the national treatment standard, *de facto* restriction of the market is equally liable to challenge under GATS, not just *de jure* restriction.

21 For discussion of a parallel threat from GATS to the restriction of alcohol advertising on public health grounds, see Grieshaber-Otto and Schacter (2001).

22 Similarly, GATS poses serious challenges to public health as a result of the potential impact of market access and national treatment commitments on the environment; see Waskow and Yu (2001).

23 See *The General Agreement on Trade in Services (GATS): Objectives, coverage and disciplines*, at http://www.wto.org/english/tratop_e/serv_e/gatsqa_e.htm

24 For examples of regulatory capture by US pharmaceutical companies, often working in conjunction with US government representatives, see Madeley (1999), chapter 10; for similar details of corporate pressure on national intellectual property regimes, both by individual pharmaceutical companies and by industry lobby groups, see Oxfam briefing papers on GlaxoSmithKline and Pfizer (Oxfam 2001a and 2001b).

25 "The increasing trend towards uncontrolled privatization may result in a proliferation of health services with little guarantee of quality of care. Poor men and women risk investing scarce resources for ineffective treatment." (WHO 2000b)

26 "Effective regulatory capacity is essential if policies that encourage private sector participation are to be successful, *a fortiori* if that participation is foreign." (Kinnon 1995)

27 A parallel conflict between GATS and the right to "the highest attainable standard of physical and mental health" as enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights is discussed in Bronson and Lamarche (2001).

28 GATT Article XX(b) is the General Exceptions article of GATT, the opening sections of which read: "Subject to the requirement that such measures are not applied in a manner which would constitute a means of arbitrary or unjustifiable discrimination between countries where the same conditions prevail, or a disguised restriction on international trade, nothing in this Agreement shall be construed to prevent the adoption or enforcement by any contracting party of measures: (a) necessary to protect public morals; (b) necessary to protect human, animal or plant life or health."

29 The UK government supports the call for an assessment of GATS, as confirmed by DTI Minister Nigel Griffiths in his 20 July 2001 response to a written parliamentary question from Nigel Jones MP.

30 GATT Article III.8(b) reads: "The provisions of this Article shall not prevent the payment of subsidies exclusively to domestic producers, including payments to domestic producers derived from the proceeds of internal taxes or charges applied consistently with the provisions of this Article and subsidies effected through governmental purchases of domestic products."

Bibliography

Adams, O. and Kinnon, C. (1997) *Measuring trade liberalization against public health objectives: the case of health services*. WHO Task Force on Health Economics, Geneva.

Adlung, R. and Carzaniga, A. (2001) 'Health services under the General Agreement on Trade in Services'. In *Bulletin of the World Health Organization*. Vol. 79 (4), pp352-364.

Africa Group (2001) *WTO Africa Group: Joint Proposal on the Negotiations on Agriculture*. WTO Document No. G/AG/NG/W/142, Geneva.

Ahmad, M. (1999) *Pakistan and the GATS: An Assessment of Policies and Future Prospects*. Paper presented to WTO 2000 South Asia workshop, New Delhi, 20-21 December.

Annan, K. (2000) *Impact of Globalization on Social Development*. Report of the Secretary-General to the Special Session of the UN General Assembly, April 2000, UN document A/AC.253/25.

Annan, K. (2001) *We the Children: End-decade review of the follow-up to the World Summit for Children*. Report of the Secretary-General to the Special Session of the UN General Assembly on Children, UN document A/S-27/3.

Bailey, M., Mayne, R. and Smith, M. (2001) *Fatal Side Effects: Medicine Patents under the Microscope*. Oxfam, Oxford.

Bayliss, K. (2000) *The World Bank and Privatisation: A flawed development tool*. Public Services International Research Unit, London.

Bengoa, J. (1997) *The relationship between the enjoyment of human rights, in particular economic, social and cultural rights, and income distribution*. Final Report of Special Rapporteur José Bengoa to the 49th session of the UNHCHR Sub-Commission on Prevention of Discrimination and Protection of Minorities, June.

Berg, J. and Taylor, L. (2000) *External Liberalization, Economic Performance, and Social Policy*. Center for Economic Policy Analysis, New York.

Bettcher, D.W., Yach, D. and Guindon, G.E. (2000) 'Global trade and health: key linkages and future challenges'. In *Bulletin of the World Health Organization*. Vol. 78 (4), pp521-534.

Bloom, G. and Lucas, H. (2000) *Health and Poverty in Sub-Saharan Africa*. IDS Working Paper 103, Institute of Development Studies, Brighton.

Bradshaw, J. (2001) 'Child poverty under Labour'. In Fimister, G. (ed) *An End in Sight? Tackling child poverty in the UK*. Child Poverty Action Group, London.

Bronson, D. and Lamarche, L. (2001) *A Human Rights Framework for Trade in the Americas*. International Centre for Human Rights and Democratic Development, Montreal.

Butkeviciene, J. (2000) 'Movement of Natural Persons under GATS'. In *A Positive Agenda for Developing Countries: Issues for Future Trade Negotiations*. UNCTAD, New York and Geneva.

CEO (1999) *WTO Millennium Bug: TNC Control over Global Trade Politics*. Corporate Europe Observatory, Amsterdam.

Chadha, R. (2001) 'GATS and Developing Countries: A Case Study of India'. In Stern, R.M. (ed) *Services in the International Economy*. University of Michigan Press, Ann Arbor.

Chavez, J.J. (2001) *The Asian Financial Crisis and Filipino Households: Impact on Women and Children*. Focus on the Global South, Bangkok, and Save the Children, Quezon City.

Chisvo, M. (2000) *Reaping the Whirlwind: Economic Liberalisation and Food Security in Zimbabwe*. CIIR, London.

Cornia, G.A. (1999) *Liberalization, Globalization and Income Distribution*. UNU World Institute for Development Economics Research, Helsinki.

Cornia, G.A. (2001) 'Globalization and health: results and options'. In *Bulletin of the World Health Organization*. Vol. 79 (9), pp834-841.

Cornia, G.A. and Mwabu, G. (1997) *Health Status and Health Policy in Sub-Saharan Africa: A Long-Term Perspective*. UNU World Institute for Development Economics Research, Helsinki.

CSI (1999) *Services 2000 USTR Federal Register Submission*. Coalition of Service Industries response to Federal Register Notice of 19 August 1998: Solicitation of Public Comment Regarding US Preparations for the World Trade Organization's Ministerial Meeting, Fourth Quarter 1999.

CSI (2001) *Open Letter from CSI President Robert Vastine to Ambassador Zoellick, United States Trade Representative, regarding the Temporary Entry of Natural Persons*. Coalition of Service Industries, Washington DC, 27 July.

Cuba et al. (2000) *Agreement on Agriculture: Special and Differential Treatment and a Development Box*. Proposal to the June 2000 Special Session of the Committee on Agriculture by Cuba, Dominican Republic, Honduras, Pakistan, Haiti, Nicaragua, Kenya, Uganda, Zimbabwe, Sri Lanka and El Salvador, WTO Document No. G/AG/NG/W/13, Geneva.

Das, B.L. (1998) 'Restoring balance to services in WTO'. In *SUNS* No. 4336, Geneva, December.

Edworthy, S.M. (2001) 'Telemedicine in developing countries'. In *British Medical Journal*. Vol. 323, pp524-525.

EI and PSI (1999) *The WTO and the Millennium Round: What is at stake for Public Education?* Education International, Brussels, and Public Services International, Ferney-Voltaire.

European Commission (1999) *Where Next? The GATS 2000 Negotiations*. European Commission 'Info-Point' on World Trade in Services: http://gats-info.eu.int.

European Communities (2000) *GATS 2000: Environmental Services*. Communication from the European Communities and their Member States, WTO Document No. S/CSS/W/38, Geneva.

European Communities (2001) *Domestic Regulation: Necessity and Transparency*. Communication from the European Communities and their Member States, WTO Document No. S/WPDR/W/14, Geneva.

Fabe, P.A.H. (2001) *Migration and Children: The case of Barangay Suba, Cebu City*. Save the Children, Quezon City.

Francois, J. and Wooton, I. (2001) *Market Structure, Trade Liberalization, and the GATS*. Centre for Economic Policy Research, London.

Gaffney, D., Pollock, A., Dunnigan, M., Price, D. and Shaoul, J. (1999) 'Planning the "new" NHS: downsizing for the 21st century'. In *British Medical Journal*. Vol. 319, pp179-184.

Gangari, A.M. et al. (2001) *West Darfur State: Broad Household Food Analysis for Drought Affected Population*. Save the Children, World Food Programme and Sudan Ministry of Health, Khartoum.

GATT (1990) *Thailand – Restrictions on Importation of and Internal Taxes on Cigarettes*. GATT 1990 Panel Report No. DS10/R, adopted 7 November.

Godfrey, C. (1998) *A Future for Caribbean Bananas: The Importance of Europe's Banana Market to the Caribbean*. Oxfam, Oxford.

Gould, E. and Joy, C. (2000) *In Whose Service? The threat posed by the General Agreement on Trade in Services to economic development in the South*. World Development Movement, London.

Government of British Columbia (2001) *GATS and Public Service Systems: The GATS 'governmental authority' exclusion*. Government of British Columbia, Victoria BC.

Gray, J. (1998) *False Dawn: The Delusions of Global Capitalism*. Granta, London.

Green, D. and Priyadarshi, S. (2001) *Proposal for a 'Development Box' in the WTO Agreement on Agriculture*. CAFOD, London, and South Centre, Geneva.

Grieshaber-Otto, J. and Schacter, N. (2001) *The GATS: Impacts of the international 'services' treaty on health-based alcohol regulation*. Paper presented to the 27th Annual Alcohol Epidemiology Symposium of the Ketil Bruun Society for Social and Epidemiological Research on Alcohol, Toronto, 28 May to 1 June.

Gupta, I., Goldar, B. and Mitra, A. (1998) 'The Case of India'. In Zarrilli, S. and Kinnon, C. (eds) *International Trade in Health Services: A development perspective*. UNCTAD and WHO, Geneva.

Hall, D. (2001a) *Globalisation, Privatisation and Healthcare – A preliminary report*. Public Services International Research Unit, London.

Hall, D. (2001b) *The Public Sector Water Undertaking – A necessary option*. Public Services International Research Unit, London.

Harper, C. and Marcus, R. (1999) *Child Poverty in Sub-Saharan Africa*. Save the Children, London.

Hartridge, D. (1997) *What the General Agreement on Trade in Services Can Do*. Address to British Invisibles and Clifford Chance conference 'Opening Markets for Banking Worldwide: The WTO General Agreement on Trade in Services', London, 8 January.

Heaton, A. (2001) *Joint Public Private Initiatives: Meeting children's right to health?* Save the Children, London.

Hennig, R.C. (2001) 'IMF forces African countries to privatise water'. www.afrol.com, 8 February.

Hilary, J. (1999) *Globalisation and Employment: New opportunities, real threats*. Panos Institute, London.

Hoekman, B. (1999) *Towards a More Balanced and Comprehensive Services Agreement*. World Bank, Washington DC.

Howse, R. and Mutua, M. (2000) *Protecting Human Rights in a Global Economy: Challenges for the World Trade Organization*. International Centre for Human Rights and Democratic Development, Montreal.

Hufbauer, G. and Warren, T. (1999) *The Globalization of Services: What has happened? What are the implications?* Institute for International Economics, Washington DC.

ICN (1999) *Nurse Retention, Transfer and Migration*. Position Statement, International Council of Nurses, Geneva.

IFPRI (2001) *2020 Global Food Outlook: Trends, Alternatives and Choices*. International Food Policy Research Institute, Washington DC.

Ikiara, G.K., Muriira, M.I. and Nyangena, W.N. (2001) *Professional Services in Kenya: Constraints and Opportunities for Trade*. Coordinated African Programme of Assistance on Services (CAPAS), UNCTAD, Geneva.

India (2000) *Proposed Liberalisation of Movement of Professionals under General Agreement on Trade in Services (GATS)*. Communication from India, WTO Document No. S/CSS/W/12, Geneva.

ISODEC and GCI (2001) *Water Privatisation in Ghana? An Analysis of Government and World Bank Policies*. Integrated Social Development Centre, Accra, and Globalization Challenge Initiative, Takoma Park.

Jha, R. (2000) *Reducing Poverty and Inequality in India: Has Liberalization Helped?* UNU World Institute for Development Economics Research, Helsinki.

Karsenty, G. (2000) 'Assessing Trade in Services by Mode of Supply'. In Sauvé, P. and Stern, R.M. (eds) *GATS 2000: New Directions in Services Trade Liberalization*. Brookings Institution, Washington DC.

Kinnon, C. (1995) *WTO: What's in it for WHO?* WHO Task Force on Health Economics, Geneva.

Koivusalo, M. (1999) *World Trade Organisation and Trade-Creep in Health and Social Policies*. STAKES, Helsinki.

Komives, K., Whittington, D. and Wu, X. (2001) *Access to Utilities by the Poor: A Global Perspective*. UNU World Institute for Development Economics Research, Helsinki.

Krajewski, M. (2001) *Public Services and the Scope of the General Agreement on Trade in Services*. Center for International Environmental Law, Geneva.

Kuttner, R. (1998) 'Must Good HMOs Go Bad?' In *New England Journal of Medicine*. Vol. 338 (21-22), pp1558-1563, 1635-1639.

Lamy, P. (2001) 'EU hangs tough on agriculture and environment in a new WTO round'. Interview with EU Trade Commissioner Pascal Lamy. In *World Trade Agenda*, Vol. 1 (15), 30 July.

Lipson, D.J. (2001) *GATS and Trade in Health Insurance Services*. Working Paper No. WG4:7, WHO Commission on Macroeconomics and Health, Geneva.

Lobina, E. and Hall, D. (1999) *Public Sector Alternatives to Water Supply and Sewerage Privatisation: Case Studies*. Public Services International Research Unit, London.

Low, P. and Mattoo, A. (1999) *Is There a Better Way? Alternative approaches to liberalization under the GATS*. Paper presented to the PECC TPF conference 'East Asia and Options for WTO 2000 Negotiations', Manila, 19-20 July.

Lundberg, M. and Squire, L. (1999) *The Simultaneous Evolution of Growth and Inequality*. World Bank, Washington DC.

Madeley, J. (1999) *Big Business, Poor Peoples: The Impact of Transnational Corporations on the World's Poor*. Zed Books, London and New York.

Madeley, J. (2000) *Trade and Hunger: An Overview of Case Studies on the Impact of Trade Liberalisation on Food Security*. Forum Syd, Stockholm.

Malhotra, K. (1998) *Economic Renovation, User Fees and the Provision of Basic Services to Vulnerable Families: Lessons for Vietnam*. Paper for Save the Children Alliance, Vietnam, and UNICEF, Vietnam.

Mandil, S.H. (1998) 'TeleHealth: What is it? Will it propel cross-border trade in health services?' In Zarrilli, S. and Kinnon, C. (eds) *International Trade in Health Services: A development perspective*. UNCTAD and WHO, Geneva.

Marcus, R. (2001) *Kyrgyzstan Case Study – Social Safety Nets Project*. Save the Children, London.

Marcus, R. and Wilkinson, J. (2001) *Whose Poverty Matters? Social Protection and PRSPs*. Save the Children, London.

Mashayekhi, M. (2000) *GATS 2000 Negotiations: Options for Developing Countries*. Paper delivered to Third World Network seminar 'Current Developments in the WTO: Perspectives of Developing Countries', Geneva, 14-15 September.

Mattoo, A. (1999) *Developing Countries in the New Round of GATS Negotiations: From a Defensive to a Pro-Active Role*. Paper delivered to WTO/World Bank Conference on Developing Countries in a Millennium Round, Geneva, 20-21 September.

Mehrotra, S. (2000) *Integrating Economic and Social Policy: Good Practices from High-Achieving Countries*. Innocenti Working Paper No. 80, UNICEF Innocenti Research Centre, Florence.

Milanovic, B. (1999) *True World Income Distribution, 1988 and 1993: First calculation based on household surveys alone*. World Bank, Washington DC.

Murphy, S. (1999) *Trade and Food Security: An Assessment of the Uruguay Round Agreement on Agriculture*. CIIR, London.

Mwanza, A. (1999) *Effects of Economic Reform on Children and Youth in Zimbabwe since 1991*. Save the Children, Harare.

Nichol, A. (1998) *Carrying the Can: Children and their water environments*. Save the Children, London.

Nigam, A. and Rasheed, S. (1998) *Financing of Fresh Water for All: A Rights Based Approach*. UNICEF Staff Working Papers EPP-EVL-98-003, UNICEF, New York.

Norton, A., Maxwell, S. and Lovell, E. (2000) *Globalisation, Poverty and Children: A Concept Paper for UNICEF*. Overseas Development Institute, London.

OECD (2001) *Development Co-operation Report 2000: Statistical Annex*. OECD Development Assistance Committee, Paris.

Oulton, J. (1998) 'International Trade and the Nursing Profession'. In Zarrilli, S. and Kinnon, C. (eds) *International Trade in Health Services: A development perspective*. UNCTAD and WHO, Geneva.

Oxfam (2001a) *Dare to Lead: Public Health and Company Wealth*. Briefing Paper on GlaxoSmithKline. Oxfam, Oxford.

Oxfam (2001b) *Formula for Fairness: Patient Rights before Patent Rights*. Briefing Paper on Pfizer. Oxfam, Oxford.

Page, S. (1999) *Globalisation: The Linkages to Poverty and to Children*. Overseas Development Institute, London.

Pavignani, E., Colombo, A., Beattie, A. and Noormahomed, A.R. (1998) 'The case of Mozambique'. In Zarrilli, S. and Kinnon, C. (eds) *International Trade in Health Services: A development perspective*. UNCTAD and WHO, Geneva.

Pollock, A. and Price, D. (2000) 'Rewriting the regulations: how the World Trade Organisation could accelerate privatisation in health-care systems'. In *The Lancet*. Vol. 356, pp1995-2000.

Price, D., Pollock, A. and Shaoul, J. (1999) 'How the World Trade Organisation is shaping domestic policies in health care'. In *The Lancet*. Vol. 354, pp1889-1892.

PSI (1999) *The WTO and the General Agreement on Trade in Services: What is at Stake for Public Health?* Public Services International, Ferney-Voltaire.

Sen, A. (1999) *Health in Development*. Keynote address to the 52nd World Health Assembly, Geneva, May.

Sexton, S. (2001) *Trading Health Care Away? GATS, Public Services and Privatisation*. The Corner House, Sturminster Newton.

Simms, C., Rowson, M. and Peattie, S. (2001) *The Bitterest Pill of All: The collapse of Africa's health systems*. MEDACT and Save the Children, London.

Sinclair, S. (2000) *GATS: How the World Trade Organization's new 'services' negotiations threaten democracy*. Canadian Centre for Policy Alternatives, Ottawa.

Sinclair, S. (2001) *The GATS negotiations: 'state of play'*. Briefing Paper Series Vol. 2, No. 2, Canadian Centre for Policy Alternatives, Ottawa.

Sitthi-amorn, C., Somrongthong, R. and Janjaroen, W.S. (2001) 'Some health implications of globalization in Thailand'. In *Bulletin of the World Health Organization*. Vol. 79 (9), pp889-890.

Smith, E., Brugha, R. and Zwi, A. (2001) *Working with Private Sector Providers for Better Health Care: An Introductory Guide*. London School of Hygiene and Tropical Medicine, London.

Smithson, P. (1994) *Health financing and sustainability: A review and analysis of five country case studies*. Save the Children, London.

Stephenson, S. (1999) *Approaches to Services Liberalization by Developing Countries*. Organization of American States, Washington DC.

Stocker, K., Waitzkin, H. and Iriart, C. (1999) 'The Exportation of Managed Care to Latin America'. In *New England Journal of Medicine*. Vol. 340 (14), pp1131-1136.

Swan, M. and Zwi, A. (1997) *Private Practitioners and Public Health: Close the Gap or Increase the Distance?* London School of Hygiene and Tropical Medicine, London.

Thankappan, K.R. (2001) 'Some health implications of globalization in Kerala, India'. In *Bulletin of the World Health Organization*. Vol. 79 (9), pp892-893.

Ugaz, C. (2001) *A Public Goods Approach to Regulation of Utilities*. UNU World Institute for Development Economics Research, Helsinki.

UNCTAD (1996) *Report of the United Nations Conference on Trade and Development on its Ninth Session, held in Midrand, South Africa, from 27 April to 11 May 1996*. UNCTAD Document No. TD/378, Geneva.

UNCTAD (1997) *International Trade in Health Services: Difficulties and Opportunities for Developing Countries*. UNCTAD Document No. TD/B/COM.1/EM.1/2, Geneva.

UNCTAD (1999a) *World Investment Report 1999: Foreign Direct Investment and the Challenge of Development*. UNCTAD, Geneva.

UNCTAD (1999b) *Assessment of Trade in Services of Developing Countries: Summary of Findings*. UNCTAD Document No. UNCTAD/ITCD/ TSB/7, Geneva.

UNCTAD (2000a) *Handbook of Statistics 2000*. UNCTAD, New York and Geneva.

UNCTAD (2000b) *A Positive Agenda for Developing Countries: Issues for Future Trade Negotiations*. UNCTAD, New York and Geneva.

UNCTAD (2001) *World Investment Report 2001: Promoting Linkages*. UNCTAD, Geneva.

UNDP (1997) *Human Development Report 1997: Human development to eradicate poverty*. UNDP, New York.

UNDP (2000) *Human Development Report 2000: Human rights and human development*. UNDP, New York.

UNICEF (2001) *The State of the World's Children 2001*. UNICEF, New York.

UNICEF et al (1998) *Implementing the 20/20 Initiative: Achieving universal access to basic social services*. Joint publication of UNDP, UNESCO, UNFPA, UNICEF, WHO and World Bank, New York.

Vallejo Mestres, M. (2000) *Rural-Urban Labour Migration: General Patterns*. UNICEF-China, Beijing.

Vandemoortele, J. (2000) *Absorbing Social Shocks, Protecting Children and Reducing Poverty: The role of basic social services*. UNICEF Staff Working Papers EPP-00-001, UNICEF, New York.

Vander Stichele, M. (1998) *Towards a World Transnationals' Organisation?* Transnational Institute, Amsterdam.

Vignon, J. (1997) 'Europe and Globalisation: An interview with Jérôme Vignon, Chief Adviser at the Commission's Forward Studies Unit'. In *The Courier* (European Commission), No. 164, pp58-62.

de Vylder, S. (2000) *Macroeconomic Policies and Children's Rights*. Save the Children Sweden, Stockholm.

Waddams Price, C. and Young, A. (2001) *UK Utility Reforms: Distributional Implications and Government Response*. UNU World Institute for Development Economics Research, Helsinki.

Wagstaff, A. (2000) 'Socioeconomic inequalities in child mortality: comparisons across nine developing countries'. In *Bulletin of the World Health Organization*. Vol. 78 (1), pp19-29.

Wagstaff, A. (2001) *Poverty and Health*. Working Paper No. WG1:5, WHO Commission on Macroeconomics and Health, Geneva.

Waskow, D. and Yu, V.P.B. (2001) *A Disservice to the Earth: The Environmental Impact of the WTO General Agreement on Trade in Services (GATS)*. Friends of the Earth USA, Washington DC.

Watkins, K. (1997) *Cost-recovery and equity in the health sector: issues for developing countries*. Oxfam, Oxford.

Whitehead, M., Dahlgren, G. and Evans, T. (2001) 'Equity and health sector reforms: can low-income countries escape the medical poverty trap?' In *The Lancet*. Vol. 358, pp833-836.

WHO (1999) *Interim Report of the Biennium, February 1999*. Action Programme on Essential Drugs, Document No. WHO/ HTP/EDM/ MAC(11)/99.4, WHO, Geneva.

WHO (2000a) *World Health Report 2000 – Health Systems: Improving Performance*. WHO, Geneva.

WHO (2000b) *Gender, Health and Poverty*. WHO Fact Sheet No. 251, WHO, Geneva.

WHO and UNICEF (2000) *Global Water Supply and Sanitation Assessment 2000 Report*. WHO, Geneva, and UNICEF, New York.

Winters, A. (2000) *Trade, Trade Policy and Poverty: What are the Links?* Centre for Economic Policy Research, London.

Woodward, D. (1996) 'Effects of globalization and liberalization on poverty: concepts and issues'. In *Globalization and Liberalization: Effects of International Economic Relations on Poverty*. UNCTAD Publication No. UNCTAD/ECDC/ PA/4/Rev 1, UNCTAD, New York and Geneva.

Woodward, D. (1998) *Globalization, Uneven Development and Poverty: Recent Trends and Policy Implications*. SEPED Working Paper 4, UNDP, New York.

Wootton, R. (2001) 'Telemedicine'. In *British Medical Journal*. Vol. 323, pp557-560.

World Bank (2000a) *World Development Report 2000/2001: Attacking Poverty*. World Bank, Washington DC.

World Bank (2000b) *World Development Indicators 2000*. World Bank, Washington DC.

World Bank (2001) *Global Economic Prospects and the Developing Countries 2001*. World Bank, Washington DC.

Wright, D. (1998) 'Telemedicine and developing countries: A report of study group 2 of the ITU Development Sector'. In *Journal of Telemedicine and Telecare*. Vol. 4, Suppl. 2, pp1-85.

WTO (1995) *Government Procurement of Services*. WTO Secretariat, Document No. S/WPGR/W/3, Geneva.

WTO (1996) *United States – Standards for Reformulated and Conventional Gasoline*. Report of the Panel, WTO Document No. WT/DS2/R, Geneva.

WTO (1997) *European Communities – Regime for the Importation, Sale and Distribution of Bananas*. Report of the Appellate Body, WTO Document No. WT/DS27/AB/R, Geneva.

WTO (1998) *Health and Social Services*. WTO Secretariat, Document No. S/C/W/50, Geneva.

WTO (1999a) *The Developmental Impact of Trade Liberalization under GATS*. WTO Secretariat, Job No. 2748/Rev.1, Geneva.

WTO (1999b) *Application of the Necessity Test: Issues for Consideration*. WTO Secretariat, Job No. 5929, Geneva.

WTO (1999c) *Article VI:4 of the GATS: Disciplines on Domestic Regulation Applicable to All Services*. WTO Secretariat, Document No. S/C/W/96, Geneva.

WTO (2000a) *Agricultural Trade Performance by Developing Countries 1990-1998*. WTO Secretariat, Document No. G/AG/NG/S/6, Geneva.

WTO (2000b) The Effects of the Reduction Commitments on World Trade in Agriculture. WTO Secretariat, Document No. G/AG/NG/S/11, Geneva.

WTO (2001) *Market Access: Unfinished Business – Post-Uruguay Round Inventory and Issues*. WTO Special Study No. 6, Geneva.

Xing, H. (1998) 'The Case of China'. In Zarrilli, S. and Kinnon, C. (eds) *International Trade in Health Services: A development perspective*. UNCTAD and WHO, Geneva.

Zhou, H. (2000) *A Report on Migration and Children*. Save the Children, Beijing.