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HEALTH IS NOT FOR SALE

Guaranteeing universal access to quality health care

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INTRODUCTION

Health is a basic right. International treaties and agreements oblige countries to guarantee that everyone can exercise this right. Is the right to health, however, compatible with economic interests? What are the impacts of free trade agreements on the healthcare of countries in the South with whom the European Union has concluded and/or is negotiating an agreement?

These policy briefs from the North-South working group of the Action Platform Health and Solidarity and the working group on Social Determinants of Health of Be-cause Health focus on various aspects of the impact international trade policy has on health. The policy briefs examine the following topics: international trade policy and the right to health in relation to (1) intellectual property rights (TRIPS), (2) decent work and (3) universal health coverage. universal health coverage.

ABSTRACT

As a response to financial and geographical barriers to health care access, many developing countries are moving forward to Universal Health Coverage, frequently understood as a financing arrangement to ensure people can access the health services they need without incurring a financial risk. Underlying this approach are global health policies that tend to promote an increased commercial sector involvement in health and the liberalization of service sectors by means of trade and investment agreement.

Such agreements are however undermining equity in health care access. In order to ensure real universal access to quality health care, strong health systems need to be developed in all their aspects, including access to essential medicines and technologies and a sufficient capacity of well-trained and motivated health workers, all of which are jeopardized by these free trade deals. Governments therefore need to guarantee policy coherence for health and ensure that trade and investment agreements do not undermine health care access.

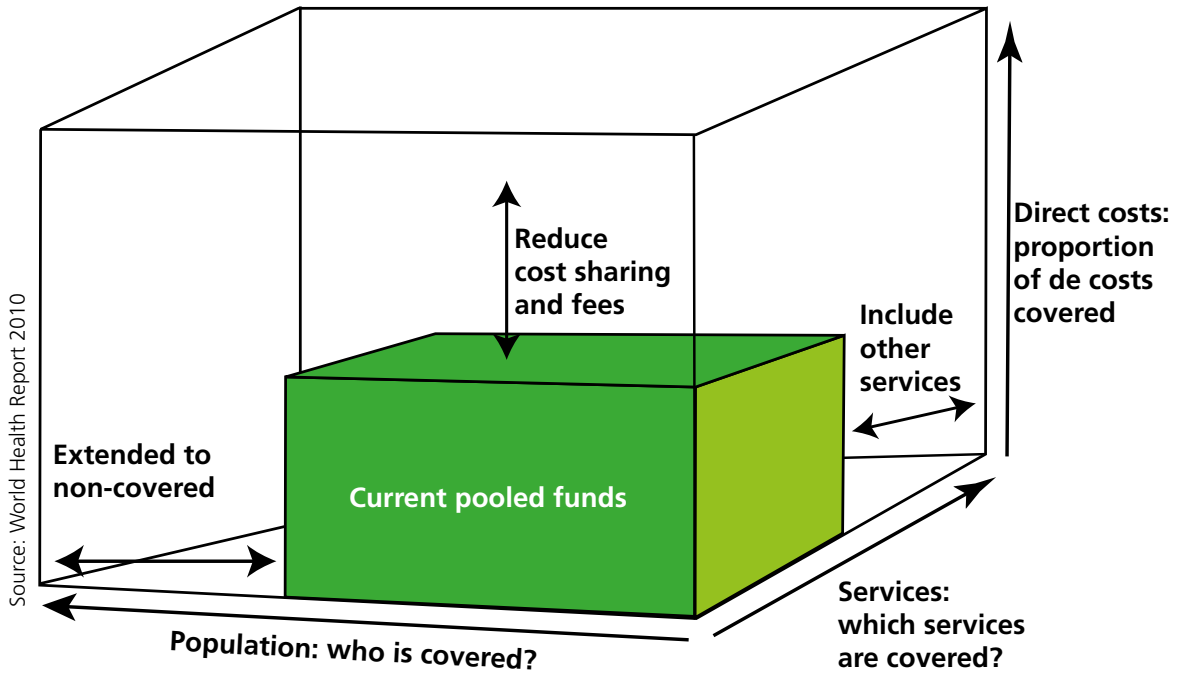
1 Universal health Coverage VS Universal Health Care

Large disparities exist in health between developing and rich countries. Low and middle-income countries bear 90% of the global burden of disease, but account for only 12% of global spending on health[1]. In other words, the most vulnerable people with the greatest health needs have poor access to health care. In fact, 1.3 billion people on the planet have no affordable and effective access to health care.

Today, Universal Health Coverage (UHC) is often put forward as a solution[2] to improve access to health care in developing countries. UHC is defined by the World Health Organization (2010) as "ensuring that all people obtain the health services they need without suffering financial hardship when paying for them". According to the WHO[3], Universal Health Coverage as a concept is "firmly based on its Constitution of 1946[4], declaring health a fundamental human right".

The 2010 World Health Report, Health systems financing: the path to universal health coverage[5], illustrated the concept with the 'UHC cube' (see figure), in which there would be a progressive expansion of (1) the package of services covered for (2) the entire population as (3) pooled funds increase to finance health care.

Three dimensions to consider when moving towards universal coverage



Source: World Health Report 2010

This model is gaining popularity. Since 2010 more than 80 countries have asked the WHO for technical assistance in moving toward this goal. The emerging economies of Brazil, Russia, India, China and South Africa (the BRICS), representing almost half of the world's population, are all taking steps toward UHC. In 2012, the UN General Assembly passed a landmark resolution[6] calling on member States to adopt UHC policies and, more recently, the International Labour Organisation (ILO) also jumped on the bandwagon[7]. Both the World Bank[8] and the World Health Organisation (WHO) have proposed UHC as one of the key components of the Sustainable Development Goals finalized in September 2015[9].

However, even though many powerful global health actors are now advocating for UHC, including the World Bank and WHO, private players such as the

Gates and the Rockefeller Foundations and influential academic outlets such as The Lancet, the concept is interpreted in different ways. Does UHC mean universal health insurance coverage? Or does UHC mean providing quality health care for all? What role should the state play? Must one rely on the private sector?

Focus on finances

The concept of UHC is not entirely new and, from its early days, the emphasis was put on 'sustainable financing'. One of the first mentions of UHC was at the 58th World Health Assembly in 2005, where a resolution[10] urged member states to "ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health care expenditure and impoverishment of individuals as a result of seeking care."[2] This recommendation was based on some experiments in the late 1990s and early 2000s with such universal insurance schemes, especially in Latin American countries[11]. Today, the policy prescription that has come to dominate the UHC agenda is the implementation of insurance schemes covering a limited package of health services.

A health system is more than a financing arrangement

While there is much debate about health financing arrangements to achieve universal access to health services, other key health system aspects such as health service provision have largely been off the radar. Mainstream research on UHC[12] focuses on health financing by the State but generally limits its role to that of 'purchaser' of health services, pushing aside its previously key provider role[13]. Paradoxically, the WHO recognizes that UHC requires a strong, efficient, well-run health system; access to essential medicines and technologies and a sufficient capacity of well-trained and motivated health workers[14]. Vivian Lin, health systems director at the WHO regional office for the Western pacific reported in The Lancet that "financial risk protection alone is not enough, and that without the availability of quality health care, UHC is meaningless" (2014b).

UHC turning a blind eye on commercialization of health care

At the same time, civil society organizations have warned that the UHC prescription has come to be dominated by the use of insurance schemes that weakens public health systems, by leaving the door open for the privatization of health care delivery[15]. Exemplary of this trend is the European Union Development Cooperation's Agenda For Change[16] pushing for more involvement of the private sector. It states that "the European Union should only invest in infrastructure when the private sector is not able to do so on a commercial basis". The European Commission wants to create a favourable business environment[17] in developing countries and 'catalyze private investments'. The document furthermore stipulates that "the EU should develop new ways of engaging with the private sector, notably with a view to leveraging private sector activity and resources for delivering public goods", including health care. In a press release[18] (May 13, 2014, p 13) then European Commissioner of Development Cooperation Andris Piebalgs confirmed that the Commission aims to foster partnerships with private companies in order to 'provide basic services, such as energy, water, health care and education.

2 Trade and health

According to the European Commission, privatization and trade liberalization go hand in hand. The Agenda For Change states: "better and more targeted Aid for Trade and trade facilitation must accompany these [privatization] efforts". Governments promote trade and investment as a means to economic growth and seek reductions in non-tariff barriers including on essential services such as health or education. This shows the complete disregard for the role of the state to regulate commercial health providers, in order to protect the public interest.

Trade negotiations within the World Trade Organization

Multilateral, regional and bilateral free trade agreements affect health services directly, through trade in health services, and indirectly, through liberalization in support sectors and an impact on people's daily living conditions and the environment. The World Trade Organization (WTO) provides a multilateral framework for trade liberalization with binding agreements for member states[19]. The General Agreement on Trade in Services (GATS) under the WTO outlines the pathways through which trade affects health services, namely via medical tourism, E-health, health worker migration and foreign direct investment[20] on health infrastructure for example. The biggest risk of trade in health services consists in the creation of a two-tiered system with mainly private, highly technological and specialized care for the affluent few and basic, under resourced, public health services for the poor, as well as the exacerbation of an international brain drain through health worker migration and internal brain drain from public to private services. Because of this, the poor in rural and urban areas would have deteriorating access to quality health services.

The new regime: WTO put out of action

Because of increasing resistance from developing countries within the WTO, economically powerful nations such as the USA and the European Union are now placing more emphasis on bilateral and regional trade and investment agreements, circumventing the WTO to advance the trade agenda. This 'new generation' trade and investment agreements - among which the Trade In Services Agreement (TISA) and the Transatlantic Trade and Investment Partnership (TTIP) and the Trans Pacific Partnership (TPP) - currently being negotiated, seek to liberalize service sectors with increasing commercialization in health care as a consequence, by following the same logic as but going beyond the GATS requirements.

Public policy space in danger

Consequently, Liberalization in the service sector effectively undermines governments' public policy space. Decisions taken by current governments will be captured in a binding agreement, with an effective dispute settlement mechanism. Such a mechanism allows private companies to sue governments if measures are taken that might negatively impact the businesses profit making. Moreover If, after having liberalized and commercialized the health sector it seems that it would be better to keep or return health care in public hands to have universal access, then it would be very difficult, if not (legally) impossible to reverse negative consequences of previously done commitments. Therefore it is important to thoroughly assess the potential impacts on health and access to health care before committing services to trade liberalization under binding agreements.

3 Position

Universal health care through public action

The narrowly defined scope of Universal Health Coverage, where the issues of financing and management are divorced from health care provision and where the delivery of services becomes less a responsibility of the government but more a pluralistic mix that includes the private sector and civil society, can result in diminished access to health care.

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In fact, a health system should not be a mere aggregate of dispersed facilities and service providers, but an integrated network of facilities and services that are appropriately situated at primary, secondary and tertiary levels. The UHC sole focus on health financing to secure health care access is in sharp contrast with the vision of Primary Health Care envisaged in the Alma-Ata declaration of 1978, which calls for the building of health systems that would provide comprehensive care, would be integrated, organized to promote equity, and driven by community needs.

Health systems that rely mainly on public provisioning and financing of health care perform better in terms of equitable access to health care. A single public system also seems to perform better in terms of efficiency, while more privatized systems are more fragmented and incur more transaction costs. For example, a comparison of the Chilean and Costa Rican health systems shows that the Chilean market where private and public insurances coexist is detrimental to efficiency[21]. The dominant public health sector in Costa Rica shows better access to health services, while spending less on health than Chile. The Cuban example[22 23 24] underlines that good health outcomes are possible to achieve through a single public health system and a focus on comprehensive primary health care. Other countries have increased the availability of health services by investing in public health infrastructure (Thailand[25], Sri Lanka[26]).

Commercialization of health care undermines access

In addition, outsourcing of health care provision to commercial investors is detrimental to the public sector because it diverts away scarce resources. One example is how the presence of the private for-profit sector in the Philippines or the export of health workers is enticing health workers away from the public sector by offering higher salaries[27]. This so-called internal and international "brain drain" can undermine the rural availability of health care in developing countries. It is depriving the local population of access to essential health services by creating a shortage of health workers in the public sector and in rural areas. Contrarily, countries that offer hefty incentives to retain health workers in the public sector or in rural areas (Sri Lanka, Cuba) have successfully promoted equitable service delivery.

No trade in health services

Because of the risks for equity in access to quality health care and the obligation to respect, fulfill and protect the 'right to health and health care' for all people equally, governments need to be careful in committing service sectors to trade liberalization. Even more so because trade agreements are binding and it becomes therefore difficult if not impossible to reverse any negative consequences in a later stadium.

It is of utmost importance to respect the precautionary principle, meaning that no binding agreements could be signed before evidence exists that population health and health care access would effectively be protected. Health and social impact assessments should be made mandatory and the results should guide decisions. Additionally, there should be a carve-out for the health system in trade and investment agreements, enabling the state to safeguard health care access.

CONCLUSION

The poor track record on access to health care in developing countries is exacerbated by corporatization policies in the health sector. Opening up the health sector for increased private-for-profit investments is exacerbating inequity in access to health care and thus inequity in health outcomes, which raises serious concerns of social justice. Although important, health insurance coverage alone cannot achieve universal access to health services if other health system aspects, such as financially unaffordable health services and insufficient availability of health workers, simultaneously undermine health outcomes.

Therefore, the European Union should refrain from development policies that support or push corporatization efforts in the health sector. Instead, the EU should promote health policies that ensure affordable, accessible, qualitative and acceptable health care for all and are consistent with the 'right to health', in order to achieve universal health coverage and real inclusion of people living in developing countries. Strong public health systems need to be developed, including access to essential medicines and technologies, availability of health care infrastructure and well trained and motivated health workers. In addition, policy coherence for health should safeguard health and health care access, through excluding the health system from trade and investment agreements, enforcement of the precautionary principle and making health and social impact assessments mandatory.

POLICY RECOMMENDATIONS

In General

In order to ensure real universal access to quality health care, strong health systems need to be developed in all their aspects, including access to essential medicines and technologies and a sufficient capacity of well-trained and motivated health workers. In this context, the definition of Universal Health Care as a financing system is to narrow to sufficiently contribute to the goal of Universal Health Care, and governments should advocate a broader definition. Governments need to take up their role as a public actor and need to guarantee policy coherence for health and health care access and ensure that trade and investment agreements do not undermine these goals.

Specific

In the development of future and ongoing health systems, the EU should:

1. Advocate these to be in accordance to the vision of Primary Health Care envisaged in the Alma-Ata declaration of 1978, which calls for the building of health systems that would provide comprehensive care, would be integrated, organized to promote equity, and driven by community needs.
2. Respect the precautionary principle
3. Make Health and social impact assessments mandatory and take decisions along the results.
4. Enable the role of the government to safeguard equitable health care access by excepting the health system in trade and investment agreements
5. Refrain from development policies that support or push corporatization efforts in the health sector.
6. Promote health policies that ensure affordable, accessible, qualitative and acceptable health care for all and are consistent with the 'right to health', in order to achieve universal health coverage and real inclusion of people living in developing countries.

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