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Trade in Health Services
Implications for People’s Health*

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Abstract
The neo-liberal transformation of global economy has brought in a new trade regime replacing GATT 1947 with incorporation of services and intellectual property in the products to be exchanged and WTO as its powerful regulator. Health being one of the services has become tradable for the first time. India has chosen to engage in health trade substantially to drive economic benefits from medical tourism, export of pharmaceuticals and manpower, and to carry out contract clinical trials. This has resulted in a paradigm shift in the role of state in the provisioning of health services with very adverse implications for the access of poor to the health care services and quality of public health system. India should therefore firmly oppose further liberalization of health sector in any future negotiations in the WTO.

Keywords
Trade, Healthcare, Medical Tourism, Drug Availability, Public Health System

Thrust of Globalisation
Globalisation has virtually emerged as the ideology of our times. Its impact on the economy, society and polity can hardly be missed. Triggered by global economic forces of investment capital, finance and trade, the revolutionary changes in information and communication technology have shaped a new development paradigm with market as its pivot. This development model has aggressively

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displaced the welfare state consensus accepted since the World War II. The transformation is being steered by three global governance institutions viz., the International Monetary Fund (IMF), the World Bank and the World Trade Organisation (WTO), the first through macroeconomic management, the second through provision of development finance and investment and third through trade. The normative framework of ‘welfare state’ was built on a delicately crafted balance between the imperatives of economic growth and the demands of social development. Good health being necessary as much for personal well-being and social progress as for economic development, the provision of health care to the people constituted an important component of social development. This balance has been aggressively replaced by a tilt towards economic growth with deleterious effects on the human and social development. Health sub-sector, therefore, cannot remain untouched by this change.

Health outcomes in a society are influenced by activities in the economy, social practices and cultural values. Three factors contribute towards them. The first relates to living conditions which prevent occurrence of ill health. The access to food security, balanced nutritional diet, safe drinking water, sanitation arrangement, et cetera, is necessary for it. The second is availability of health services which include preventive and curative medicine and hospital care. The developments resulting from consumption of products, use of services and social intercourse also produce profound consequences for health. This constitutes the third factor. Market driven changes represented by globalisation have affected all the three factors. The living conditions for a large section of people have deteriorated as the role of State has shrunk in the subsidised provisioning of various social services resulting from the IMF mandated restructuring of the economy. The access to health services and quality of care for those who cannot afford to pay have worsened under the impact of reforms introduced by the World Bank. The international trade regime is not only commodifying health care but is also introducing new threats to health, some of which are beyond the capacity of the State to prevent or control. The structure and processes of WTO are even reducing State’s capacity to design health policy and regulations autonomously. It is difficult to apportion precisely the influence of the three institutions on each of the three factors affecting people’s health as their activities overlap considerably and are also strongly integrated in terms of the ideological thrust towards neo-liberalism.

The health care system in India after Independence took shape broadly on the lines recommended by the Bhore Committee. This has been getting slowly dismantled since the economic and health sector reforms were introduced beginning with the 1990s though some change in thinking could be noticed even earlier. A great deal has been written on the impact of these reforms (Qadeer et al., 2001). International trade, however, has received little attention in this discourse. One reason could be that the movement for reforms in health system started earlier while the new international trade regime came into existence later. The other reason perhaps is that the threats to health from trade unravel

slowly while those emerging from economic and development policies create more pronounced and immediate impact. Also, perhaps, the predominantly public funded health system was not perceived to carry much potential for trade and, therefore, liberalisation of economy to facilitate trade posed less of a threat. The added difficulty is that tradable health goods and services are spread over diverse sectors and an integrated picture is not easy to figure out. But, in view of its wide-ranging ramifications, international trade would produce far more damaging consequences on health of the people than what the market-driven changes in health services have inflicted so far. This is due to the paradigmatic change that has occurred in the new global trade regime from that of the previous General Agreement on Tariffs and Trade (GATT) 1947, in terms of reach, intensity, powers and the directional thrust.

New Trade Regime

The following features of new trade regime distinguish it from its predecessor:

- The scope of trade has been widened from exchange of products to incorporate services, intellectual property and life forms. Health sector activities constitute one of the services and have, therefore, become tradable for the first time.
- The discourse on trade and its operations has shifted attention from tariff concessions and transgressed into the arena of domestic policy and regulations, resulting in reduced role of nation state in governance (Obrien et al., 2000).
- The framework of negotiations has moved from terms of exchange relating to products to creating conditions for facilitating competition.
- The WTO is more institutional and powerful than its predecessor in view of the punitive instruments available to it for seeking compliance of its decisions.
- The processes of trade negotiations and decisions pursue an expansionary agenda through ‘deeper integration’ and ‘policy harmonization’ in respect of subsidies, investment and services (Shukla, 2002).
- The trade regime has empowered itself to take decisions on matters having a bearing on fields other than trade for which it has no expertise.
- The mode of decision-making in the existing trade body reflects democratic deficit as the decisions can be enforced on unwilling members (Helleiner, 2002).

In view of the above architecture of the trade regime and the enormous power appropriated by it, some understanding of its structure, operational processes and the evolving credo is necessary to assess the impact of its activities on health currently and in future.
Institutional Arrangements

The new institutional trade arrangements emerged after the conclusion of Uruguay Rounds in 1994. Their ambit is defined by various multilateral agreements which consist of twenty nine individual legal texts covering a wide range of subjects from agriculture to intellectual property. This is supplemented by more than twenty five ministerial declarations, decisions and understandings. General Agreement on Trade in Services (GATS) is one of these wide ranging multilateral agreements. Health sector is one of the twelve sectors listed in GATS. Of the wide range of multilateral agreements which WTO administers, GATS deals with exchange of services. It is considered to be the single most important development in multilateral trading system since GATT (1947). It makes no distinction between public services or those provided for profit. Only, the service which state provides entirely free and without any competitor is out of its ambit (Sexton, 2003; Bertrand and Kalafatides, 2001). Services include 160 items and health is one of them. Health care dimensions are involved in some other agreements as well. Among the agreements more directly affecting health are the Agreement on Application of Sanitary and Phytosanitary Measures (SPS), Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS), Agreement on Agriculture (AOA), Agreement on Technical Barriers to Trade (TBT), GATT. Health outcomes may also emerge from operation of trading activities in other sectors through pattern of investment, production, consumption and exchange of products, use of technology, human and cultural intercourse. But GATS has wider ramifications and implications for the health sector compared to the other agreements. This article will, therefore, deal with GATS in relation to health services.

GATS identifies four ways (‘or more’) in which services can be traded. These are: Mode-1: Cross Border Supply-Services applied from one country to another. Mode-2: Consumption Abroad-Consumers/organisations making use of a service in another country. Mode-3: Commercial Presence-A foreign country establishing a unit to provide services in another country. Mode-4: Movement of Natural Persons-Individuals going over from one country to another to supply services. Each country has to incorporate in its declaration of obligations and restrictions relating to Market Access and National Treatment in respect of each sub-sector. Market Access implies treating all countries alike and National Treatment requires treating foreign and domestic suppliers on equal footing. Where no restriction is indicated, the commitment is BOUND; where restriction/limitation is indicated, the entry in UNBOUND.

The unique feature of the current trade system is that a distinct entity has been created to regulate international trade which had not existed earlier. This is called the WTO. The overarching consideration for the WTO is that there should be no restriction in trade between nations. National policies, regulations and governing structures should conform to this objective. The trade principles it enforces for this purpose are Market Access (treating all countries alike) and the National
Treatment (considering foreign and domestic suppliers on equal footing). WTO is also unique in that it makes its own rules which evolve through its operations. It pursues an evidence based system within the structure of a rule based organisation (Orbinski, 2001). Of the rules which define its working, the most overriding is the primacy of trade over other considerations. Exemptions contained in any agreement which permit trade to be restricted on grounds of public health, environment, social protection, etc. are narrowly interpreted by it so as to favour the cause of trade (Hong, 2000). The other is that when a country raises any issue against unrestricted trade, such as risk to public health or damage to environment, WTO rules seek convincing scientific basis for such contentions (Wallach, 2001). As a result, it has disallowed ‘precautionary principles’ as the basis for restricting trade where the scientific evidence does not exist or is weak in the short run even though potentially serious risk may emerge later. WTO also takes the position that there should be no distinction between like products irrespective of how they are produced (Hong, 2000). All such products should be treated in a similar manner so that the national governments are discouraged from restricting or avoiding import of certain products on the ground of risk to public health from a process of production.

**WTO and Health**

Even in a short period of its existence, WTO has taken far-reaching decisions which have wide-ranging implications outside the trade sector. Health and Environment are among the affected sectors. Though some agreements permit a member country to restrict trade in the interest of public health, WTO rulings have upheld the interest of trade and disregarded/undervalued objections relating to health, as for example, in the hormone treated beef case between European Union (EU) and United States of America (USA) (Wallach, 2001; Retallack, 2001). The insistence in this case on production of conclusive scientific evidence concerning risk to public health by the state rather than transferring the burden of proof on the industry to deny the existence of such risk clearly displayed tilt against public health.

The adverse decisions of this sort have weakened the ability of countries to respond to health threatening situations. The prospects of a possible challenge of decisions in the WTO are forcing them to change or remove their health safety regulation standards to avoid punitive consequences (Wallach, 2001). The South Korean action in shortening production inspection turnaround time to permit marketing of food products before carrying out the microbial tests, Thailand’s decision to disband its consumer pricing board for medicine and Guetamala’s capitulation in exempting imported baby food products from the purview of its breastfeeding promotion law provide evidence of this behaviour (Bertrand and Kalafatides, 2001; Wallach, 2001).
WTO rulings are also undermining national priorities in health related matters as, for example, evidenced by US being forced to change its clean air regulations governing petrol cleanliness against challenge by Venezuela and Brazil (Wallach, 2001). Its actions are virtually determining standards of public health regulations for which it does not have the necessary expertise. Its decisions rely on bodies which are driven by commercial interests (Codex Alimenterius in food products) rather than on the advice of international expert bodies such as the Food and Agriculture Organisation (FAO) and World Health Organisation (WHO) (Hong, 2000). As more such decisions are delivered, WTO takes on the mantle of domestic policymaking and dictates the agenda which a country should adopt, thereby encroaching on the domain of the sovereign legislature in terms of the existing national laws (Shukla, 2002). India’s decision to enact amendments to the Patents Act (1999) to provide for exclusive marketing rights and arrangements to receive product patent applications in the interim period was an instance of compliance of WTO direction although the government considered it unnecessary in view of the executive action it had already undertaken in the matter.

GATS laid down general framework of trade in services and mandated further negotiations to liberalise services within a period of five years. The first phase of these negotiations incorporated the following three safeguards. Each country is empowered to regulate supply of services in accordance with its national policies. It can restrict entry of foreign suppliers to specified services under stipulated conditions. The developing and least developed countries would be allowed flexibility in implementation of decisions. The 2001 Doha Ministerial Declarations incorporated these aspects in the Doha Development Agenda. Further progress in the matter has not been registered due to acute difference of opinion between developed countries and developing countries. The overall position is that of all the services, health sector has attracted the least number of commitments and achieved the least level of liberalisation in the initial offers from member countries and Doha declaration has made no advances. It has virtually been a ‘non event’ with only eleven out of ninety five members making improved commitments. This has led critics to declare that GATS is not a liberalising force (Adlung, 2009). The commitments are 2.3 times more restrictive than the current policies and do not reflect the liberalisation that has already taken place (Gootiiz and Mattoo, 2009).

**India’s Position on Commitments under GATS**

India submitted its conditional initial offer during the process of negotiations on GATS–94 under Article 19 and in pursuance of para 15 of Doha Ministerial Declaration. This offer has been made subject to:

- Other members making substantive and satisfactory offers in sectors and modes of supply where India had indicated its interest.

India would have a right to withdraw, modify or reduce any part of its offer and any subsequent conditional offer that may follow, in whole or in part, at any time and/or prior to the conclusion of the negotiations.

India also reserves the right to make any technical amendment or correction, initially or subsequent conditional offer.

The outcome of negotiations in progress on development of discipline of domestic regulation.

There are four categories of services which together constitute health services: (a) medical and dental services, (b) services of nurses, midwives, etc (c) hospital services, and (d) other human health services. In the revised proposal, India offered to undertake extensive commitments under Modes 1 and 4. In addition, India substantially improved access in critical service sectors. Which in the context of health care: (a) medical and dental services, (b) services provided by midwives, nurses, physiotherapists and para-medical personnel, (c) health services and, (d) tourism services. While making commitments under different modes, it has recorded commitments and limitations in respect of Market Access and National Treatment covering all four categories of health services. The limitations, wherever recorded, largely relate to provision of services on provider to provider basis under Mode 1, foreign equity ceiling and its conditionalities, Foreign Investment Promotion Board (FIPB) approval in case of foreign collaboration under Mode 3, access to scheduled and tribal areas and the period of stay of foreign professionals under Mode 4 in Market Access and differentially priced services to foreigners and public funded services only to Indian citizens, subsidies, where granted, only to domestic service suppliers, preference for service suppliers who offer best terms for transfer of technology, special treatment to Scheduled Castes (SCs)/Scheduled Tribes (STs) and weaker sections in National Treatment.

In terms of the offer made, India has opened up the service sector substantially. This will have its impact on the health sector as some inter-connectivity is embedded in GATS. Sequencing of commitments may lead to opening up of other sectors earlier. The domestic economy may react to such changes in market demand structure which may affect health sector (Sahni and Kala, 2004). But even with regard to the health sector itself, India has opened up under all four Modes of supply taking into account its perception about the competitive advantage and the existing pattern of health services export. Under Mode 1, it is telemedicine. Medical tourism has weighed in making commitments under Mode 2. Clinical trials for drugs may have been in view as business process outsourcing under Mode 1. India has opened up Mode 3 both for attracting investment internally and exporting services which include besides hospitals, medical education and research services. Mode 4 has been high on the agenda of negotiations as it involves export of service providers which meets stiff resistance from developed countries in the shape of various restrictions. The overall position of commitments made by other countries points towards ‘unevenness’ in Market Access particularly in Mode 4 where India is most interested. Even limited commitments made by various countries have been further narrowed down by Horizontal Limitations, like economic
and market needs tests, licensing and recognition requirements, immigration regulations. GATS, like all other WTO agreements, is not neutral to the capacity and competitive ability. The opening up of its market would, therefore, benefit foreign suppliers enormously due to their control over capital and technology. It would also be conditioned by unequal power relations in global negotiations which would determine who is able to extract what concessions. Developed countries are seeking limitation free access and broad liberalisation in the form of Horizontal Commitments across all four modes (Abrol, 2003). The apprehension is that India may be forced to make more liberal commitments which may have adverse equity implications. It may also be vulnerable to negotiation deals struck across sectors whose implications for health would be difficult to predict. This apprehension is reinforced by the statement of the Union Commerce Minister (Business Standard, 2005) that India was willing to consider flexibilities in Mode 1 and Mode 3 of services as a probable bargaining point to seeking flexibility in Mode 1 and Mode 4 where India had ‘extensive interest’ in liberalising export of services. The prospects of enlarged commitments and shrinking of limitations are therefore on the cards whenever a final agreement is reached and health sector may also be a part of this deal. The economic growth obviously takes precedence in India’s overall position under GATS and equity dimensions in health care take a back seat. This is likely to be the trend future negotiations as well.

Commitment to Integrate with Global Economy: Liberalisation in Health Sector

Apart from the specific commitments made under GATS which may have implications for the health sector, government has repeatedly expressed its commitment to integrate the country with the global economy and, accordingly, liberalised its policies to facilitate this process. This includes the health sector. Health sector also cannot be insulated from impact of activities in other sectors. In the current regime of international trade, Multinational Companies (MNCs) backed by their home (developed) countries are looking for even a little opening in developing countries to ensure that the existing protective mechanisms are dismantled as trade barriers. This opening has already been created by liberalising the health care services for entry of the private sector not merely as a parallel provider but as a partner in public funded health services. As a result of the latter, the state funded health segment is no longer ‘a supply in exercise of government authority’ to claim exemption from the operations of GATS.

Trade Liberalisation in Health Sector

While some trading activity has taken place in certain segments of health sector such as pharmaceuticals, medical manpower even prior to the onset of
globalisation, a major thrust in this direction has come after the establishment of WTO. Health sector covers a wide gamut of products and services under GATS. For the government, however, attracting medical tourists and clinical trial business and export of drugs and manpower is on the top of the agenda.

**Medical Tourism**

a) Medical Tourism:  
Government has been actively promoting medical tourism to its medical facilities which provide services at much cheaper rates than those charged in developed countries but are of comparable quality. It anticipates huge foreign exchange earnings from this trade. This objective is enshrined in the National Health Policy, 2002 and the Tenth Five Year Plan. The Corporate/Private Health Sector, and the tour and travel operators have undertaken various promotional measures to attract foreign tourists (Reddy and Qadeer, 2010). Some state governments such as Karnataka, Kerala, and Maharashtra have also done likewise to publicise health care facilities in their jurisdiction for this purpose.

b) Development and Fiscal Policies:  
The opening up of insurance sector, 100 per cent Foreign Direct Investment (FDI) in health care and automatic approvals of their investments proposals, setting up of a venture capital fund to promote drugs discovery and infrastructure in Pharma Sector, amended Patents Act are some of the measures introduced to give a push to trade in the Health Sector. Some corporate/private hospitals have already benefited from supply of land at concessional rates, infrastructure development and tax exemption/reduction for import of medical equipments. The Pharma and Health Care industry has been active to cash on this opportunity and have tied up with MNCs for this purpose. The pharmaceutical companies have also upgraded their infrastructure facilities, rationalised their product portfolio and increased their Research and Development (R&D) budget besides scouting for acquisition of companies for increasing their reach. The industry perceives trade as a knowledge transfer mechanism.

c) Clinical Trials:  
Both industry and government are promoting outsourcing of clinical trials. The steps taken to facilitate it include removal of service tax on clinical trials, incentivising government funded research and medical institutions to take up such trials in public hospitals, expeditious clearance of clinical trials projects, time bound issue of license to import supplies, training of human power in dedicated institutions, improving standards of data collection and analysis and removal of ‘phase lag’ in permitting clinical trials by amending the Drug and Cosmetic Rules, 2005 (Srinivasan, 2009).
d) Manpower Export: 
Government wishes to aggressively push removal of entry restrictions relating to economic need test, immigration policies, certification arrangements, professional qualifications and issue of visa in respect of foreign professionals imposed by developed countries during negotiations show us to benefit from remittances and upgradation of knowledge and experience.

Implications of Trade Liberalisation

State and Health Care: Paradigm Shift in the Role

Implicit in the health sector reforms carried out/under way is gradual dismantling of the public health system from its erstwhile status as a predominantly publicly funded arrangement accessible to all free of cost and without discrimination. It is now giving way to multiple channels of health care responding to the socio-economic capacity of different classes of health care seekers. This transformation has gone through a four-stage evolution:

- The first stage recognised the need for private sector developing as a parallel system of health care to tap resources outside the government for meeting the needs of the people. The National Health Policy— 1982 and the Sixth Five Year Plan document registered this catalytic step. This phase also suggested introduction of user charges and pay clinics/cabins in tertiary care units of government hospitals.
- The second stage brought in the concept of differential health care catering to different segments of population according to their paying capacity. Simultaneously, the ambit of services provided free of cost by the public health system was curtailed. Varying patterns of privatisation were also brought into the public health system through extension of paying arrangements, contracting out certain clinical and non-clinical services, shared responsibility with private sector labelled as public–private partnerships and diversification of financing sources for provisioning of health care. The Central and State health care projects financed by the World Bank operationalised some of these changes.
- In the third stage, the government went a step further towards privatisation with its policy to purchase health care services from private sector for reducing its responsibility in its provisioning. This can be seen in the arrangements evolved in externally funded projects, conceptual design of the National Rural Health Mission, the provision of reimbursement of expenditure on health care incurred in private hospital units under the Central Government Health Scheme (CGHS) and the push towards insurance driven health care for different social groups including the very poor.
The fourth stage emerges when health care services are promoted as an instrument of growth to be globally traded. This is reflected in the liberalisation of foreign direct investment in health and insurance, deregulation of pharmaceutical industry, active support to medical tourism, encouragement of outsourced clinical trials, aggressive export of manpower, et cetera.

Thus, India’s willingness to open up health sector for international trade under GATS is not a sudden decision but a culmination of progressive movement towards emulation of the health care system in the industrialised countries, particularly USA. These processes unmistakably point towards a paradigm shift in the role of state in the provisioning of health services. This shift can be conceptualised in terms of the changes occurring in following dimensions of health care: approach to health care, provision of health care, financing of health care, access to health care, and maintenance of public health.

There is a paradigm shift in the approach to Health Care from being a ‘service’ which every citizen is entitled to without discrimination and state had the responsibility to provide in the pre-reform period, it has now become a marketable commodity sold, purchased and traded at a cost. With regard to the provision of health care, the altered policy has diluted both the entitlements of citizens to get free health care without discrimination and the duty of the State to provide it. The provision of free medical care to all has been restricted to essential primary care, emergency life saving services, treatment under Disease Central Programmes, and facilities under family welfare programme. The rest has to be purchased. The universality and equality of health care has been disregarded. The State has also shed its exclusive responsibility to finance health care by diversifying financing sources of curative health care. It has promoted private sector in health, and encouraged Non-Governmental Organisations (NGOs), Community and Charitable Institutions to provide health care with a view to sharing its burden. This has drastically affected access to health care. The earlier policy of universal and equality of access has given way to differentiated access defined by affordability and payment capacity. The equality in access is eroded as multi tiered health care facilities get promoted. The poor are at the bottom of the ladder whose access gets restricted to unqualified medical practitioners in private sector and poor quality of services in Public Sector due to their inability to afford paying arrangements. The maintenance of Public Health System deteriorates due to the dwindling role of State in provision of social services, effective preventive health care and comprehensive primary health care. The introduction of privatisation has shrunk access of the poor to social services. The reduced expenditure on public health has impacted on effective reach of preventive care while the primary health care has been restricted to immunisation, emergency services, Reproductive and Child Health (RCH) and specific communicable diseases. This adversely affects conditions for attaining good health outcomes. The pre-existing inequalities in distribution of health care

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characterised by uneven spread of infrastructure and rural–urban differentials in the quality of services have widened across States, between regions and within communities (Baru et al., 2010) after the onset of economic reforms. This is sought to be neutralised by stress on health insurance. But insurance coverage both public and private is very low and even a targeted social insurance for Below Poverty Line (BPL) families does not reduce catastrophic expenditure due to its restricted application to hospitalisation episodes of serious nature (Mitchel et al., 2011). The diversification of financing health care far from addressing inequities would widen them. The iniquitous access has already produced adverse health outcomes as observed in the stagnation/deterioration levels in the poorer sections (Peters et al., 2002). Unregulated private health sector and escalating cost of care has affected the access to health care of the lower middle classes as well and would have on their health attainments.

**Distortions in Health Care**

Trade in health services is an extension of the comodification of health care with buyers and sellers cutting across national borders. It will not remove or reduce the existing inequities. Rather, it would aggravate them as the foreign suppliers join the local private sector in further skewing the distributional arrangements. The foreign direct investment in health care and the tie-up between business groups and health providers has produced a multi-tiered system in which the cost of health care, particularly in the private tertiary health care, has shot up. The categorisation, standardisation and accreditation of health care facilities would institutionalise these divisions. The promotion of medical tourism would weaken the efforts to reduce cost of public health care as well. (Sexton, 2003) The liberalisation in the insurance sector would replicate the ‘managed care’ health system of the USA which is loaded against the poor, chronically ill and the elderly besides being plagued by financial and performance problems (Krugman, 2005). The export of professional manpower would intensify the brain drain (Koivusalo, 2003) and distort the public health content of medical education and training already oriented towards specialisation and urban areas (Bajaj, 1998). This will also undermine the knowledge production system in the country to prepare the kind of medical professionals we need particularly for rural and under-served areas (Khadria, 2003). The outsourced clinical trials, given our dismal record in enforcing medical ethics would increasingly suck in the poor, uninformed and gullible patients into becoming helpless subjects for market oriented medical research, a danger to which *The Economist* caustically termed as one of ‘the odder ways in which India is making mark in services than it has ever done in manufacturing’ (*The Economist*, 2000). The organ donation in the evolving scenario may cater to the foreign patients as it is now doing the affluent Indian patients.

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Affordability of Drugs

With the coming in of TRIPS compliant patent regime, the patented drugs have become increasingly unaffordable for a large number of people, particularly the poor. This would be significantly more in the case of newly discovered drugs. Their distribution in public health services may also become difficult due to constraints of allocations. This welfare loss was anticipated by experts even before, the amendment of the Patent Act. The recourse to ‘compulsory production’ and ‘parallel imports’ by other countries for obtaining cheap drugs under TRIPS is likely to be subverted by the developed countries given the recent experience with Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) drugs (Hong, 2000). Besides, the solution would be decidedly worse for countries which have no or insufficient manufacturing capacity for taking advantage of compulsory licensing to meet their domestic health needs. They would face the most acute problem in catering to it. Pharma MNCs are also trying to bring unpatented drugs much in public demand within the ambit of ‘patents’ through some changes in the products. Certain medicines which are in low demand may go out of production altogether (Hong, 2000; Orbinski, 2001). The MNCs have even acquired patents in respect of homemade remedies from local produce such as ‘Haldi’ and ‘Neem’ and herbs used by the Indian people for healing. As there is no meticulous record of traditional knowledge in public domain, (some effort has been made in recent years) it will be difficult as well as expensive for the government to contest such patents in international courts and get them cancelled notwithstanding an odd success achieved here and there. At the same time, it will take many years and huge resources for the country to convert the rich treasure of traditional knowledge in medicines into patents by national government, companies and social organisations. There is also no evidence that with the onset of the new Patent regime, the focus of multinational pharmaceutical companies is shifting from the diseases of the affluent countries to those of the developing countries because the higher profits can be made from the former where the patients have higher paying capacity and drug penetration is high (Kulkarni, 2004). Contrary to the expectation, these companies are not locating their R&D research units in developing countries. In fact, a number of MNEs have closed down their R&D facilities in India (Lalitha, 2002). Thus, the much touted transfer of technology from developed to developing countries and setting up production facilities for drugs in them also does not materialise as the pharmaceutical firms are merely interested in the distribution of their products. The aggressive takeovers and mergers in the industry would enable them to take control of the national enterprises and their production and distribution processes as well. This development has the potential of destabilising even the national companies from primarily catering to the needs of the local people. It is also becoming evident that even the national pharmaceutical companies, like their foreign counterparts, are looking for profitable markets in the developed countries for their...
growth and development (Mishra et al., 2003). There is a shift away from bulk drugs towards high valued formulations (Jha, 2007). They are making investments in those countries, forging tie-ups with foreign companies and focusing on discovery of drugs which can capture their market (The Associated Chambers of Commerce and Industry of India, 2005). WTO regime, in any case, would make it difficult for small manufacturers to survive due to low volume, high cost and inadequate capital. India also faces the prospect of dumping of large volumes of many intermediate and bulk drugs at a much lower cost from China which would throw such producers out of market. This has already happened in Gujarat, A.P. and Karnataka (Lalitha, 2002). Besides, the changes in the patent regime have also led to decline in exports and increase in imports (Joseph, 2009). They impact both the patients and the manufacturers (Jha, 2007).

Damaged to Public Health

The trade liberalisation in health services will capture the most profitable components of public health services and would increasingly tap public funds for expansion and sustenance of their business. It will create markets in public health services where none existed earlier, thereby reorienting their character. More serious, under pressure of WTO, the existing national or local health regulations may be dismantled so as not to restrict free flow of trade. It would also fail to protect public health against factors injurious to health such as environmental degradation, bio-piracy, export of hazardous wastes, contaminated food, import of alien organisms, exports of diseased products, aggressive advertisements for consumption of potentially harmful commodities (tobacco, alcohol, soft drinks), distribution of banned and bannable drugs and equally risky combinations, promotion of health threatening food habits and cultural items impacting on life style, values and social practices, etc, (Hong, 2000; People’s Health Assembly, 2000). That some of it is already happening, as reported in the media from time to time, would suffice to convince that these apprehensions are not misplaced. There is thus an enormous potential for international trade to cause damage to public health, deepen and widen iniquities. Given the unequal power structure at the global level, the developing countries would have little leverage in protecting national interests not to speak of the interests of the poor in any international agreement on the subject which some experts suggest as a way out.

Primacy of Public Interest

Prior to the onset of economic reforms and integration with the global economy, the polity in India had been premised on the conception of a state which represented ‘public interest’ and was differentiated from ‘private interest’

of individuals, institutions or groups. The private enterprise did enjoy the constitutional freedom to operate in the economy but subject to the state policy which was committed to uphold public interest. This constituted the philosophical rationale for State to provide essential social and economic services to the people and regulate the private sector activities. Public health facilities from primary care to tertiary level were established by the government with public funds because it was in public interest to do so. Similar considerations weighed with the government in regulating the private pharmaceutical manufacturers and setting up public enterprises to produce essential drugs for making them available at reasonable prices (Sengupta, 1999). This, however, changed when the government started dismantling regulatory structures and shedding responsibilities in many areas of social provisioning. In the health sector, it first created space for the private sector to establish facilities and later even provided incentives for its growth. It also restricted access of people to subsidised public health care to facilitate expansion of private health care. The public and the private partnership was the next step in the evolution of the policy. With trade liberalisation, this process has taken a quantum leap and extended to include deregulation of licensing and control, attracting foreign direct investment, curtailing existing public funded services, creating markets in public health system for purchase of health care from private suppliers, promoting diverse financing arrangements and other facilitating instruments.

These measures would unmistakably show that state has taken a complete about-turn from its earlier stance of a tilt in favour of public interest and, at the least, neutrality between public and private interests in matters of growth. It is now actively moving to promote commercial interests. It no longer sees any contradiction between supporting private interest of health industry and serving a public purpose of providing health care to its people. Rather, it believes that the former ensures the latter. In the free trade regime with focus on export as an engine of economic growth, the state policy would increasingly uphold commercial interests, more so when it has virtually emerged as the dominant player. The creation of markets where none existed and prising open public funding for private services in health sector constitute the distinct evidence of this trend. Much greater penetration of private sector will take place as new agreements on services are concluded in the WTO. The MNCs engaged in trade in health products and services are lobbying hard backed by their national governments to remove barriers to trade in developing countries so as to create competitive environment for their entry as suppliers. They find the publicly funded health sector as a large and lucrative business opportunity easy to tap by virtue of their strength, financial and technological (Sexton, 2003). They are adopting various tactics from subterfuge to pressure and threat to get an opening so as to break the resistance of developing countries (Hong, 2000; Sexton, 2003). The public health services cannot escape increasing intrusion of foreign suppliers unless they are 100 per cent funded from public funds and without diverse providers. (Sexton, 2003) The opening of public health services to national private suppliers, even partially,
would create enough ground for foreign providers to seek entry as competitors. It would no longer be possible to ward off this contingency or even limit the competition to national suppliers.

In the new ambience of a transformed state, private sector in India has already started determining the discourse on health sector and laying down the policy on the design of health services. It is now emboldened to suggest that the government’s role in promotion of health services should remain confined to primary health care, epidemics, public health and sanitation and the rest can be catered to by the private sector (Business Standard, 2004). That this has already been accepted broadly as the policy frame shows the influence which the private industry exercises in the public policy process. The private sector now uses its clout to get decisions which serve its commercial interests. It is already lobbying for measures which can spur growth such as direct tax concessions, relaxations in the norms for setting up medical colleges and reduction exemption in indirect taxes on purchase of equipment, medicines, medical consumables and devices, etc. The health industry is actively pursuing the demand for getting the ‘infrastructural status’ with benefits like tax holiday, concessional utilities and preferential land allotments and easier terms of finance in order to create an enabling environment. But the private sector is not prepared to abide by its responsibility for free treatment to a specified percentage of poor patients in return for concessions availed of which has led the courts to take action of against them (Hindu, 2005). A more revealing fact is that even the government is now unwilling to enforce the contractual arrangement (Indian Express, 2004). This is the clearest indication yet of how health policies are and in future, would be guided by commercial considerations.

In yet another instance, striking discordance in perspective and content between the National Health Policy, 2002 (Ministry of Health Family Welfare, 2002) and the Pharmaceutical Policy, 2002, both issued in the same year, emerges from the way the latter has been entirely focused on pharmaceutical industry to the neglect of people’s interest, while the former, at least, highlights the huge challenges faced in public health from communicable and non-communicable diseases and lack of access to affordable essential drugs by a large majority of people (Bhargava, 2004). The least that was expected from the Government of India, the source of both the policies, was that Pharmaceutical Policy would harmonise with the needs articulated in the National Health Policy in making essential drugs easily available and affordable to the people. Drug prices show enormous variation in retail prices indicating huge trade margins and translate into unaffordable treatment costs. It should have put essential drugs under price control, come down heavily on continued circulation of spurious drugs, banned and irrational drugs and hazardous formulations, etc. (ibid.). While it has not taken the desired steps, the list of drugs under Drug Price Control order has been drastically reduced from 347 in 1979 to seventy four in 1995 to serve the interests of the industry. This will make off patent but essential drugs also costlier. When this order was challenged in the Karnataka High Court and stay order was granted against the operation of Drug Price Control Order (DPCO), the
Government of India filed SLP (C) 3668/2003 for impugnment of the High Court’s order (LOCOST, 2004). Several public interest bodies filed affidavits in the Supreme Court (WP (Civil) 423/2003) against the criteria for DPCO as it would increase the price of medicines and, therefore affect the health of the people and sought the Courts’ extensive directions to the Government of India to protect people’s interest (LOCOST, 2004). Government of India’s response to this petition could be deduced from the position taken by the National Pharmaceutical authority that there was no case for expanding the control list (Economic and Political Weekly, 2004).

Supreme Court vide its interim order dated, 10 March 2003 suspended the Pharmaceutical Policy, 2002 and stayed the order of the Karnataka High Court besides giving directions about formulating an appropriate criteria for keeping the essential and life saving drugs not falling out of price control and review of list of essential and life saving drugs. In response to this order, Government of India brought out an updated National List of Essential Medicines, 2003 consisting of 354 drugs. The reports of two committees set up by it (Sandhu Committee 2004 and Pronab Sen Task Force 2005) to look into the pricing issue along with the report of commission on macroeconomics and Health, 2004 endorsed the price control of drugs. The draft pharmaceutical policy, 2006 was also prepared after suspension of Pharmaceutical Policy, 2002 by the Court which has proposed that all 354 drugs in the National List of Essential Medicines, 2003 would be brought under Price Control in addition to the existing list of seventy four drugs and would apply to formulations and not bulk drugs. It has also proposed exemption of several drugs from price control along with some structural changes in the drug pricing mechanism. Due to strong objections of industry and stiff lobbying by it, however, the drug pricing issue was entrusted to another committee (Satwant Reddy Committee, 2006) which suggested that the method proposed by industry could also be one of the criteria for ensuring that essential drugs do not fall out of price control besides the cost based price control proposed by other committees. The matter was referred to the Group of Ministers for reconciling the view points of ‘stakeholders’ which could not come to a decision due to divergent opinions, resulting obviously from intense pressure exerted by industry. Meanwhile, the Parliamentary standing committee on Health and Family Welfare in its Forty-fifth Report, tabled on the 4 August 2010 in Lok Sabha recommended a blanket cap on profit margins of all medicines across the board. Government has so far conveyed no decision to the Supreme Court after the latter’s order of March 2003. The case has not yet come up for further hearing.

Similarly, on the patent law, government’s bias towards the industry was evident. The ordinance issued prior to the new enactment had reflected its anxiety to promote the interests of pharmaceutical companies rather than the concern for easy access of people to cheaper drugs—a truth which even an editorial in a premier American Newspaper was constrained to highlight (New York Times, 2005). The pressure of left parties, at least, forced the government to insert some amendments taking into account several issues raised by public interest groups. Still, the
law that has emerged fails to ‘protect the public from the aggressive monopolies that Patents confer on right holders’. The law has not incorporated flexibilities that are available within TRIPS to safeguard public interest (Gopa Kumar and Amin, 2005). But even this law is not considered sufficiently friendly to the pharmaceutical industry. There are pressures from USA, to further tighten the patent law to suit their MNCs. It is evident that the government is reluctant to expand the list of drugs in DPCO or regulate prices despite reports of the two committees set up by it, recommendations of the Parliamentary standing committee on Health and Family Welfare and approve the draft pharmaceutical policy, 2006 due to the pressure of the pharmaceutical lobby, ignoring the stark reality of 500–600 million people in the country lacking regular access to essential medicines and cost of medicines forming up to 50 per cent of medical expenditure of which 80–90 per cent is out of pocket (Economic and Political Weekly, 2006). Even the unnecessary, unscientific and therapeutically useless drugs have not been weeded out for the same reason (Srinivasan and Bhargava, 2006). Meanwhile, the situation of overpricing of drugs continues unabated and has aggravated in many ways. The petitioners have moved the Court for issue of directions for regulation and control of medicines, vaccines, sera and biological products.

Medical education is yet another area where public interest will be ignored. With its declared commitment to push export of manpower under GATS, the government would have to remodel curricula of medical education and training to suit the needs of the foreign market. The pressure would also come from the health personnel intending to migrate. Government is already lobbying for relaxation of entry restrictions and norms of qualifications imposed by developed countries. It is seeking acceptance for formulation of international standards which would be acceptable across countries. This obviously implies that the syllabi of medical teaching in future would be determined by foreign markets rather than the needs of our own health system, epidemiological profile and socio-economic conditions besides, commercialisation of medical education has already pushed up the cost of entry which has barred access to large segment of population besides affecting its quality adversely (Bhargava, 2010).

Government is already faced with increasing demand to purchase more health services from the private suppliers in its public health system which has already enjoyed huge subsidies in its growth. The liberalisation of insurance sector would facilitate this trend. That the government may be moving in this direction is indicated from a reported proposal (not a decision yet) to explore the possibility of converting CGHS into an insurance policy. A national health insurance scheme (Rashtriya Swasthya Bima Yojana [RSBY]) for the rural poor has already been put in place. National Rural Health Mission has also outlined District Missions’ Strategy to move towards paying hospitals for services by way of reimbursement. All this indicates that government is increasingly changing over to a purchaser rather than a supplier of health services.

The promotion of medical tourism as a policy would inevitably and increasingly lead to decisions about health care facilities suited to commercial interests.
The industry is keen to utilise its facilities which remain underutilised due to a small number of high-end income users. One of its demands was to categorise hospitals according to costs, quality and range of services. Government has recently enacted the clinical establishments (Regulation) Act, 2010 which would presumably workout such a classification institutionalising multi-tiered health care infrastructure. The easy import of latest equipment and consumables to suit foreign patients has been permitted at the behest of the industry. Government is also planning to develop tourism infrastructure so as to synchronise it with Medicare. These technology centric islands of excellence would push up the cost of health care. This may serve the interests of industry but would enormously hurt public interest with resultant distortion in the demand structure (Godwin, 2004). Public sector health services would be faced with growing pressure to emulate these standards with neither the need nor resources to match them. This would have negative effect on the quality of care. It may also lead to unethical organ transplantation and medical research (ibid.). Even from the view point of financial gains, the enthusiasm of policymakers about medical tourism is overstated due to over competition involving thirty five countries serving a little more than million medical tourists annually, low returns on investment and incommensurate gains compared to resources spent. On the other hand, diversion of scarce resources from the addressing the health needs of people would be incompatible with the social objectives of universal access, quality of services and seriously constrain realisation of Millennium Development goals (Cattaneo, 2009). But there is also considerable scepticism about the potential of medical tourism to attract quality conscious western patients merely on cost grounds (Marcelo, 2003).

Clinical trials carry few benefits but enormous risks to health and safety of the subject population. India has fallen into the trap set by industry and western research institutions in this regard. The drug industry sponsoring clinical trials is not interested in meeting prevailing health challenges such as infectious diseases which are a major killer each year in India but in diseases and patients that assure highest financial returns. This orient the focus towards diseases in the developed countries where nationals have paying capacity and drug penetration is very high. Most of the recent drugs are merely an improved version over the existing therapies aimed at extending the patient life without offering significant benefits but are more expensive than the older drugs. Besides, there is little possibility that the drugs tested here would be introduced in the country at prices which people can afford. Government also has not extracted such a commitment from the concerned companies before consenting to their clinical trials. This is unethical since the risks are borne by the people while the benefits are derived by others. The increasing linkages of academic/research institutions with drug/pharmaceutical industry has led to a shift in the focus of research and raised other ethical problems such as recruitment practices in clinical trials and impact on publication of clinical data. Also, this has resulted in public resources (infrastructure and scientists) being used to further the commercial interests of industry rather than to
address the health priorities of society. The regulatory guidelines of Indian Council of Medical Research (ICMR) and provisions of the Drugs and Cosmetics Act are ineffective in protecting the interests of subject participants. Some of the clinical trials are camouflaged as research and demonstration projects and there is lack of clarity about the objectives, and serious concerns about the process of approval, nature of selection of the area subjects, lack of full and complete information, monitoring, the manner of obtaining consent and follow up of those who have been administered drugs/vaccines have emerged from studies even in trials carried out by government agencies with the knowledge and collaboration of ICMR (Srinivasan, 2009; Bagla, 2007). The situation where such trials are carried out by private agencies would be worse (Sarojini, Anjali and Ashalata, 2010).

Even premier medical institutions of the country are not free from lack of observance of the guidelines issued by ICMR which, pending enactment of a law, require ethical review and monitoring of trials by the Ethical Committee. But the compliance of these requirements is very poor. The regulatory authority, that is, Drug Controller General of India carries out no site inspections or data audit in respect of these trials leaving the entire responsibility to Contract Research Organisations (CROs) or sponsors. It is not difficult to imagine the resultant hazards to the subjects. Lack of adequate funding by the government for medical research even in its own reputed institutions is driving them to accept projects which compromise public interest. The research budget of All India Institute of Medical Sciences (AIIMS) from internal resources is a mere 0.1–0.2 per cent of the total budget (Saraya, Anoop, 2010). Clinical trials also undermine the integrity of investigators through financial inducements, disregard risks to participants and at the same time do not produce a scientific innovation to justify it. There is little technology transfer since the industry has complete control over trial design, access to raw data and its interpretation. The outsourcing of clinical trials to CROs and site management organisations and competition for obtaining projects have further undermined the scientific rigour of the work and selection of participants.

Even in respect of preventive health, the decisions to pursue aggressively (even obsessively) the goal of eradication of polio, continue with Vit.-A food supplements, addition of Hep. B as also pressure for inclusion of expensive vaccines of little utility like pentavalent in the ambit of universal immunisation involving huge public resources are influenced by commercial interests, national and international and not determined by priorities based on our epidemiological situation and needs of the society (Mittal, 2005). Government may simply shrug off its responsibility having issued ethical guidelines through its apex medical research agency. But such guidelines would have dismal prospects of effective enforcement, given the TRIPS complaint provisions regarding restrictions on disclosure of information, the absence of statutory safeguards and implementation machinery and the incapacity of the affected subjects to seek accountability against violations. The prospects of economic growth and pressure of the industry outweigh known hazards to the lives and health of the clients.

Regulation of Private Sector

Health sector reforms have helped private health sector emerge as a dominant player. The rationale for health sector reforms is based on the supposed efficiency and quality of the private health care as against the public health services. This assumption has, however, been disproved by studies which have exposed the poor quality of care, unnecessary investigation and surgery, sub-standard health facilities, unsatisfactory working conditions, untrained health care providers, violation of laws and high cost of care in the private sector (Nandraj, 1994). Obviously, the market has failed to regulate these problems. The consumer pressure does not emerge due to the vulnerability of patients and the supplier dominance. Effective regulations are, therefore, needed to protect consumer interests against malpractices due to asymmetry of information between service providers and patients (Cattaneo, 2009). But the health sector in India is very weak in this regard even compared to the more market-friendly countries (Jessani, 2002). There is virtually no regulation of the private sector health care. Even the few regulations that exist in the country are poorly enforced (Mishra, et al., 2003). The trade liberalisation would increase the need for regulation more and better rather than less to adopt higher standards of service supply by hospitals and clinics. Trade Promotion, even its protagonist’s caution, is not to denigrate public health system which is crucial to meet the health needs of people and conduct of medical education. It should ‘not only be seen as a source of income in balance of payments but primarily a means to remedy shortages and improve domestic health system’ (Cattaneo, 2009: 4).

The efforts at regulating private health sector, however, present a dismal picture. Three arrangements exist to regulate private sector at present. One is the regulatory bodies, such as medical councils at the Central and State levels whose mandate is to discipline medical practitioners and set standards. The other consists of the laws, viz., the Drug and Pharmaceutical Act, the Consumer Protection Act and laws relating to organ transplants, sex determination diagnostic tests, food adulteration, environmental pollution, etc besides state laws regarding health establishments. The third is the recourse to judicial action by consumers. But all these instruments have failed to deliver. There is a rare case where punitive action is awarded by a state or Central Medical Council even when formal complaints are registered (Bhatt, 1996). The Councils are termed ‘useless’ even by professionals besides being plagued by corruption. There is strong resistance from professional groups towards self regulation (Iyer and Jessani, 2004). Most states, in any case, do not have laws for regulation of private hospitals, nursing homes, diagnostic centres and pathological laboratories. Those which have such laws have not updated them to remove loopholes (Bhatt, 1996). Only nine states have such laws (A.P, Maharashtra, Delhi, Madhya Pradesh, Manipur, Nepal and Odisha, Punjab and West Bengal). Of them, only A.P. law is relatively recent. In Maharashtra, the Bombay Nursing Homes Regulation Act was enacted in 1949 but the rules were not prepared for 55 years and the draft rules prepared after this huge delay are pending for approval for four years (Phadke, 2010). The Central
laws relating to drugs and pharmaceuticals, organ donation, female foeticide, food adulteration and pollution, have failed to create any deterrence, considering the number of prosecutions launched and convictions achieved. The situation has led to Supreme Court’s interventions in some Public Interest Litigation (PIL) cases for strengthening the regulatory regime and its enforcement. The recourse to judicial action by consumers is time taking, costly and visited by retaliation in varied forms such as inappropriate care and defensive medicine. This then highlights the enormity of the tasks involved in regulating health care.

But the State’s capacity to put in place a comprehension and effective regulatory regime has dwindled in the new political order resulting from a globalised economy; MNCs have emerged as dominant players which are not easily amenable to the discipline of national regulations for several reasons. Their headquarters/primary facilities are located outside the country. A large part of their business transactions takes place within the organisation. They threaten to retaliate with shifting production base, capital flight and withdrawal of products/facilities if action is taken against them. The pressure exerted by them through their home governments is well known (Clarke, 2001). More serious, they use the threat of raising a dispute in the WTO forum against regulatory provisions not suited to them as trade barrier. The important rulings of WTO involving health and environmental issues sufficiently underline the difficulties of any developing country to regulate the MNCs. The private sector players, national as well as international, have also resisted attempt at regulation of the prices of essential drugs or determination of optimum profit margin on them. The enforcement of ethical guidelines in the case of clinical trials and research is considerably hindered by state’s inability to access crucial information from the industry—a problem made even more difficult by TRIPS complaint Patent Law. As the international suppliers proliferate and products from foreign lands flood the market, government’s ability to protect the health of citizens has been found wanting. The export of contaminated blood products from UK to India which has remained undetected illustrates the complexity of the problem. Thus, compared to the expanding ambit of regulations required, the authority and will the Indian State to undertake them is shrinking. Unlike the pre-reform phase, the freedom of State to act against the industry to protect public interest has whittled down and space to assert its authority narrowed substantially. This is because, at the national level, it is on the industry’s piggyback that the export potential and the high rate of growth has to be realised while at the global level, the threat of an adverse ruling by WTO would always loom large.

Under great pressure from civil society and the direction of the Court, however, the Central Government has recently enacted the clinical Establishment (Registration and Regulation) Act, 2010. But the Act is not applicable to states unless consent is conveyed to adopt it through a resolution of their legislature. Besides, a lot of rule making is required before the Act gets enforced which can take enormous time. With only modest financial penalties for violation of its provisions, the Act is unlikely to create any deterrence against negligence,
substandard services and unethical practices. It is also not clear whether the Act would regulate cost of care. Most likely, it would not as the industry would oppose it. The lobby of medical professionals (Indian Medical Association [IMA]) has already made loud and ‘irrational’ protests even against such a minimal regulatory measure (Phadke, 2010). There is also a proposal to amend the Drugs and Cosmetics Act for regulating quality of blood products, conduct of clinical trials, etc. The Medical Devices Regulation Bill has also been introduced in the Parliament (Baru et al., 2010). Given the experience with other regulatory health instruments, it is to be seen whether there would be effective enforcement of these regulations when they are notified as the states lack the will and capacity for strong action.

**Autonomy to Design Health Policy**

In making health policy state in India has traditionally been influenced by considerations of equity and democratic pressures. In the pre-reform period, it has acted, by and large, to protect the interests of the people, particularly the poor and vulnerable sections, in provision of health services, the needs of the national producers and suppliers in the economy and the interest of patients against the drug industry in the market. When not under pressure of external interests, it has sought to prioritise its health care interventions taking into account the epidemiological situation and the constraints of resources and infrastructure. But the reforms carried out in health services have already eroded the structure of equity considerably by undermining state’s autonomy to design, distribute and manage health care arrangements. This is the experience of developing countries across the globe. Though rhetoric of equity may continue to be voiced and some ad hoc measures may also be taken to protect the interests of the poor, such as the National Rural Health Mission, RSBY for BPL households for meeting hospitalisation cost, or increased allocation for public health services to silence critics, the market driven approaches to health care would continue to guide its action. Trade liberalisation would increasingly interfere with domestic governance to ensure free trade and, therefore reduce state’s power to provide equitable health care since non-market devices for this purpose such as risk pooling, cross subsidisation, block contracts, etc may be declared as trade barriers. In the case of a challenge in the WTO in respect of such measures, an adverse decision would most likely to emerge and public funded services could be opened up to private sector suppliers much against the will of the government. Transparency provisions in the GATS (Article III) may expose the fragility of national regulatory mechanisms in the trade body thereby forcing the government to dilute or change them (Sahni and Kala, 2004). The country may, therefore, not be free to design health policy as per the felt needs of its people or even to determine national priorities in health care provisioning and financing arrangements. Integration with global economy would
shrink the space of manoeuvre ability since major interventions in disease control are being initiated by global players and international donors (Mittal, 2005). This has already been happening for sometime. The attention and resources bestowed on HIV–AIDS, Tuberculosis (TB) and Polio and technology choices for curative intervention have all been externally determined.

**Improvement of Public Health Services**

Prior to reforms, State sought to correct these deficiencies through expansion of health services, additional resource allocation and manpower, improving infrastructure and intensified supervision. But the health sector reforms have instead focused on promotion of private health care, purchasing health care from private suppliers, contracting out public services to private suppliers and curtailing the level of public health services rather than expanding, strengthening and improving them. The efficiency is sought to be provided by introducing private sector management in public funded primary, secondary and tertiary services, public–private partnerships and decentralisation of funding arrangements and management structures. The thrust of new strategy is on pricing open the public funded health system to private sector providers, creating internal markets and offloading the residual responsibility to lower level agencies. The fundamental issues of quality improvement are, therefore, bypassed and inspiration is sought from co-opting the private health sector. The State has thus not only abandoned the responsibility to strengthen public health sector but has virtually demonstrated a loss of faith in its capability to improve it. It looks upon private health sector as a model of efficiency and quality and is keener on emerging as a purchaser of health care rather than its dominant provider. This paradigm shift in attitude is the most debilitating threat to public funded services and equitable health care arrangement. Trade liberalisation will intensify if this denigration of public health sector as the techno-centric and high cost standards of health care set by the private sector would be difficult for it to follow.

**The Suggested Action**

What should be done to stem this onslaught of iniquitous changes and protect people’s basic right to health care?

Health of the people is far too important a matter to be sacrificed for faster economic growth. A Health Policy focused on equitable health care should be beyond compromise in any society but more so in a democracy. Trade policies may involve some give and take. But the government should be firm that it would never agree to any proposal during negotiations in international fora which dilutes...
or curtails state’s responsibility to provide equitable and need based health care to its people without being linked to the capacity of the seeker to pay (Koivusalo, 2003). This imperative must have national endorsement by the Parliament cutting across party lines. Market driven health sector reforms have already moved away from this objective. Opening up of health sector to international trade would only push this process irreversibly. A lot of damage has already been done to the health of the people by trade agreements concluded so far. With regard to GATS, no fresh agreement has yet emerged. Only negotiations have been carried out. Therefore, India can still say ‘No’ to further negotiations on trade liberalisation in the health sector. Once, however, an agreement is reached even on a limited agenda, increasing inroads would be made into the health sector by global competitors. This would set in irreversible changes which would be unstoppable. The structures of international trade, compulsions of the negotiation process, unequal global power relations and diverse pressures brought to bear on the developing countries would leave no room to scuttle the adverse effects of international agreements. If the government is genuine about its commitment to equitable health care of its people, there should be a firm ‘No’ to any negotiation on the opening up of the health sector under GATS. Unlike TRIPS, it is still possible to take this position. But this opportunity may be lost if the government goes ahead and concludes an agreement.

India should also strive for a composite stand of the developing countries as a group to keep health out of negotiations on services and to oppose primacy being given to trade against health by the WTO. But India, sadly, appears to be distancing itself from such a stand with the intention of extracting additional concessions in sectors considered more important by it. This is precisely what the developed countries and their trade interests would be looking for to divide the developing world and get through with their agenda of increasing trade liberalisation in health and other service sub-sectors. It is evident that the country’s leadership considers economic growth as an overriding priority and feels that health related adverse externalities, if any, can be managed or at least compensated by gains elsewhere. This position seriously jeopardises prospects of sustaining an equitable health care system and protecting interests of the poorer sections in this arrangement.

While GATS incorporates all services within its ambit, it excludes those supplied in ‘the exercise of government authority’. This has been interpreted narrowly to imply any service which is supplied neither on a commercial basis nor in competition with one or other service suppliers. This conservative interpretation need not apply to health services as per the view taken by the WTO council for trade. Nonetheless, the danger persists that dispute may be raised and an adverse ruling may ensue. The dilution of public health services carried out by introducing elements of privatisation such as user charges, pay cabins, contracting out services and purchasing of services from private suppliers creates the prospects of entry of foreign suppliers through a WTO decision. With a view to keeping the health services out of the trade negotiations, government should reverse the
private sector intrusion into public health services in order that the latter remain a facility entirely funded and provided by the government. Private sector in health care can exist for those who wish to avail of its services on its terms. But it should not get any concessions, incentives, subsidies for its growth or a share of market in the public health system. Rather, public health system should be strengthened in terms of resources, manpower, training, management, accountability mechanisms and quality enforcement norms. It should also revert to its comprehensive character. The secondary and tertiary care should not be delinked from it. The introduction of irritants like user charges should be withdrawn as the resources generated by it are negligible but deprivation resulting from it is extensive. Similarly, paying wards/cabins should be merged with the general wards so that limited hospitalisation services can be optimally utilised for the neediest patients. Thus, opposition to trade liberalisation in health services should accompany movement for restoration of the original Alma Ata paradigm of health care and citizen entitlement backed by statutory guarantee. It is this goal which should define the brief of the national negotiators in the international trade fora and on which no compromise should be accepted.

It is also important that health sector is not conceived as an instrument of economic growth. Such a view strikes at the root of the health care as a service for the welfare of people. Rather, healthy people are a condition for economic progress of the nation. Health services should overwhelmingly operate without an element of profit. The promotion of medical tourism, encouragement of outsourced clinical trials, vigorous export of health manpower and commercialisation of health care would introduce unalterable changes in health care system which would jeopardise people’s health. Some exchange of health services would take place, in any case, because India is a large economy and has more advanced health facilities compared to many underdeveloped countries. But it should not be promoted as a tradable commodity to generate wealth. The social cost of doing so is much too high compared to the small economic gains it may entail. This principle should be firmly embedded in the state policy and approach to international negotiations.

Trade discussions in the WTO in other sectors of services as also on other agreements involve issues supposedly outside the health sector, such as policy on procurement, competition, subsidies, investment, intellectual property rights, etc, but have many adverse implications for health care system some of which may not be comprehensible to the participants immediately. This is what has been called as ‘trade creep’ (Koivusalo, 2000). The decisions in regard to them may affect access to and quality of health services and curtail state’s power to protect people’s health. The commitment/agreement on these issues may irreversibly bind the government to serve the interest of the private sector-national and international from which it may be difficult to extricate later (ibid.). This underlines the urgency of building up expertise to examine the health implications of each agenda for discussion by a group of competent experts and social activists in order that caution is exercised at the time of negotiations. It would also be
advisable to associate some of these experts during the negotiation itself so that the new proposals coming up in the course of discussions are comprehensively analysed for the national negotiators.

A large measure of liberalisation has already taken place in the service sector and outside and more continues apace. Very little is known about its impact on the health outcomes in general and those of the poorer sections, the women, the children, the socially disadvantaged in particular. Scientifically collected information on this subject is necessary to assist negotiators in resisting further push towards trade liberalisation in global negotiations. To be equipped with adequate information on this aspect, an effective mechanism is required to be in place to provide the government with necessary feedback on this social reality. At present, a Trade and Health cell exists in the Ministry of Health and Family Welfare to assess the Impact of WTO and other trade agreements on Public health in India and suggest ways to formulate effective legislation and policy initiatives to deal with them. It is intended to provide technical assistance to the Ministry in areas of international trade related agreements. The cell is engaged to evolve policy coherence between trade policy and health policy with special focus on institutional mechanisms. The cell has been carrying out quantitative and qualitative research and analysis of international trade issues for which some studies were commissioned and completed. It has also taken preliminary steps to implement WHO Resolution 61.21 on Global Strategy and Plan of Action on Public Health (Ministry of Health and Family Welfare, 2009). Government should associate besides competent professionals, social activists and Public Advocacy organisations committed to equity concerns and place research outputs and other feedback in public domain for a wide public discussion. It should also have periodical consultations with civil society on the issue. This material should be effectively used to resist trade liberalisation in the health sector during negotiations.

As it is, even outside GATS, the disturbing effects of international trade on health outcomes are becoming increasingly evident. The deterioration in diets, aggressively induced consumption of products injurious to health, contaminated food products, etc., have already posed serious threats to health. Dumping of harmful technologies and products create health hazards difficult even to isolate let alone neutralise. The environmental degradation has deteriorated the quality of life, livelihood opportunities and food security of a large section of the people (PHA, 2000; Koivusalo, 2003). The adverse impact of cultural products is destabilising the social support and value systems which increase manifold the incidence of mental disorders. The microbial traffic through increased human contact is manifesting in new diseases and aggravation of existing ones beyond the capacity of health system to control. (Hong, 2000) This underlines the need for social science research, of a continuing nature, on the health outcomes, particularly of the vulnerable population so that government’s position is strengthened during negotiations when it resists liberalisation. Needless to say that research should be publicly funded and carried out by organisations known for their intellectual independence and social commitment.

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The suggested course of action can only be carried out by a strong state determined to assert its autonomy on Domestic Policy in the international fora, resist pressures from commercial and elite interests in the country and evolve its stand on the health sector issues through democratic consensus. Sadly, the governance in India has displayed absence of this capacity. The democratic bodies including political parties too have failed to move the government in this direction. It is time that the intense pressure is exerted by civil society through mass mobilisation to force the government to take note of people’s concerns and comprehensively accommodate them in its health policy paradigm, operational processes and negotiation strategy in the international fora. This task needs to be pursued on top priority by social and political groups cutting across their organisational boundaries and ideological lines.

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