Is trade liberalization of services the best strategy to achieve health-related Millennium Development Goals in Latin America? A call for caution

Miguel San Sebastián,[1]
Anna-Karin Hurtig,[1]
and Kumanan Rasanathan[2]

Key words: commerce, health care sector, social justice, Latin America.

[1] Umeå International School of Public Health, Epidemiology and Public Health Sciences, Department of Public Health and Clinical Medicine, Umeå University, Umeå, Sweden. Send correspondence and reprint requests to: Miguel San Sebastián, Umeå International School of Public Health, Epidemiology and Public Health Sciences, Department of Public Health and Clinical Medicine, Umeå University, SE-901 85 Umeå, Sweden; telephone: (46) (90) 785 1328; fax: (46) (90) 138 977: e-mail: miguel.sansebastian@epiph.umu.se

[2] University of Auckland, Auckland, New Zealand.

In September 2000, at the United Nations (UN) Millennium Summit, 147 heads of state adopted the Millennium Declaration, with the aim of reflecting their commitment to global development and poverty alleviation. This commitment was summarized in 8 goals, 14 targets, and 48 measurable indicators, which together comprise the Millennium Development Goals (MDGs), to be attained by 2015. All of the MDGs contribute to public health, and three are directly health-related: MDGs 4 (reduce child mortality), 5 (improve maternal health), and 6 (combat HIV/AIDS, malaria, and other diseases) (1).

Progress towards these goals has proved difficult. In an attempt to identify practical steps to achieve the MDGs, the UN Development Programme initiated the UN Millennium Project in 2002. This three-year "independent" advisory effort established 13 task forces to identify strategies and means of implementation to achieve each MDG target, and each task force produced a detailed report (2). A Task Force on Trade was created for MDG 8 to develop a global partnership for development. The mandate of the Task Force on Trade was to explore how the global trading system could be improved to support developing countries, with special attention to the needs of the poorest nations (3).

Trade is an important means of generating wealth that can lead to faster economic growth and improved health (although these are not necessarily linked). As such, it is potentially a key determinant of all the MDGs. The types of trade policies promoted thus have a significant influence on progress towards these goals.

Latin America and the Caribbean have the greatest disparities in income distribution in the world. A quarter of total income accrues to a mere 5% of the population, and the top 10% receive 40% of the total income. Poverty remains unacceptably high in Latin America (43% of the population in 2001), with the number of people living in poverty increasing from 200 million in 1990 to 214 million in 2001 (4). The Task Force on Trade recommendations are therefore especially relevant if socioeconomic and health conditions of Latin American peoples are to be improved by trade policies.

The aim of this paper is to consider the main trade policy recommendations of the report (3) as a strategy to achieve the health-related MDGs in Latin America.

TRADE LIBERALIZATION: WHO BENEFITS?

The Task Force on Trade report insists that trade liberalization is the basis for progress for developed and developing countries alike. It advocates "free" trade as the path to higher incomes and improved economic performance for all nations, on the assumption that economic growth will ameliorate absolute poverty (3). There is nothing new in this recommendation, particularly for Latin American countries. These countries have long been required to open their markets to foreign exporters as a condition for receiving aid, loans, or debt relief from donors and international financial institutions such as the World Bank and the International Monetary Fund. Experience shows that these structural adjustment policies have not been able to deliver even on their own terms (more economic growth), nor by any more meaningful measures of standard of living in Latin America (5). Latin American countries have also come under pressure to liberalize their markets in bilateral or regional negotiations with more powerful trading partners, as exemplified by the North American Free Trade Agreement (NAFTA), the Central American Free Trade Agreement (CAFTA), and the proposed Free Trade Agreement for the Americas (FTAA) (6). Regional and international trade are certainly an important focus of economic policy in Latin America. The Task Force's recommendations for rich countries to open their markets to poor countries should be supported. However, appropriate policies are required to link trade with development. Historical experience from rich countries shows that their industrial development was achieved by protecting and promoting productive sectors, especially agriculture, in order to guarantee food security and accommodate growing urban populations (7). While trade liberalization might help the poor in some circumstances, there is now robust evidence that the "free" trade model has often resulted in: (1) increased poverty and greater social inequalities, (2) the concentration of resources in multinational corporations, (3) environmental harm, and (4) the erosion of labor standards around the world (8–10). In the health sector, recent research confirms that two decades after the implementation of neoliberal reforms (such as privatization of health care systems), more resources are now spent on health care than previously, without corresponding improvements in health status or efficiency (11). Instead, fragmented health systems that exclude large groups of the population have been created. Studies conducted in a number of the countries in the Americas show that between 20% and 77% of the population cannot access health services when needed, and that an average of 78% have no health insurance (12).

IS THE GENERAL AGREEMENT ON TRADE IN SERVICES WHAT LATIN AMERICAN COUNTRIES NEED?

The Task Force on Trade considers the liberalization of services essential to the achievement of the MDGs. Its report states that access to health, water distribution, electricity, and other essential services that are currently unavailable to many of the poorest peoples globally could be improved through successful services liberalization. The report further argues that the General Agreement on Trade in Services (GATS) is the best mechanism to develop this liberalization process (3).

The GATS aims to establish a multilateral framework of principles and rules for trade in services. This Agreement defines "trade in services" unconventionally to include not just cross-border trade—where a supplier located in one country provides a service to a consumer located in another—but also other ways in which foreign suppliers can provide services. These are divided into four "modes of supply": Mode 1, cross-border services trade (for example, a medical specialist in the United States gives advice to a Nicaraguan hospital by mail, over the phone, or through the Internet); Mode 2, consumption abroad (for example, a medical student from Ecuador travels to attend university in Argentina or a patient from Uruguay receives treatment in Brazil); Mode 3, commercial presence (for example, a European health company establishes itself in Bolivia to provide medical services); and Mode 4, movement of natural persons (for example, nurses from Honduras work temporarily in Belize). The differentiation between these modes is not always clear, and not all modes of supply are equally relevant in all sectors. For instance, although it is relatively easy to conceive of medical advice being provided via all four modes, the supply of clinical nursing services does not seem to be possible under mode 1. The GATS commits World Trade Organization (WTO) members to successive rounds of negotiations "with a view to achieving a progressively higher level of liberalization" in their service sectors (13). During GATS negotiations, WTO members can negotiate which service sectors they open to foreign suppliers and the conditions under which this occurs. Countries can make market access commitments[3]—that is, refraining from establishing barriers to trade in certain sectors or subsectors—and national treatment commitments, i.e., undertaking to treat domestic and foreign companies or services equally. Unless explicitly indicated otherwise, commitments are "bound," meaning that

[3] Market access: these commitments may be subject to up to six limitations: (1) number of service suppliers, (2) value of transactions, (3) quantity of outputs, (4) number of employees in a sector, (5) type of legal form of suppliers, and (6) amount of foreign capital.

countries that modify or withdraw from the agreement become liable for requests for compensation from affected countries. In practice, this makes these commitments virtually irreversible. Commitments and their specific limitations (market access and national treatment) can be made separately for each mode in each one of the service sectors. During negotiations, countries are also asked to request liberalization of services from other countries (14). In this process, developing countries come under intense pressure to comply with the demands of more powerful WTO members—pressure that they are often powerless to resist (15, 16). For example, the European Union has asked several Latin American countries to open up their water and sanitation sectors to investment by private European companies (17).

The current round of services talks began in early 2000 and was later rolled into the broader Doha round of negotiations, which began in 2001. However, the conclusion of these negotiations by the original deadline of 1 January 2005 has not been achieved, leaving members with a longer negotiating period.

Liberalization of services occurred before the advent of GATS and would most likely continue to occur even without the existence of GATS. However, it is important to ask what GATS has contributed to this process and who the real beneficiaries of applying this regulatory framework are. The Task Force on Trade report considers the ability of GATS to lock in policy reforms to be the main incentive for translating liberalization into GATS commitments. The report states that "service negotiations offer to developing countries an opportunity to act in their own economic interest and get paid for it" (3). However, one of the most dangerous aspects of the GATS arises from the "lock-in" mechanism (that is, the "bound" nature of commitments described above), because it removes the possibility of reversing excessive or damaging future liberalization (20). For instance, the only example the Task Force provides of failed liberalization of services in developing countries is the case of water services privatization in Bolivia. The World Bank insisted that Bolivia privatize water services in Cochabamba, Bolivia's third largest city, as a condition for receiving a loan to expand the available water supply services. The contract went to a private consortium led by Bechtel, a transnational corporation based in the city of San Francisco, United States. Local cooperative water distribution systems were banned. Water became unaffordable, with prices increasing by as much as 200%. Eventually, citizen protests forced the Bolivian president to rescind the contract (19). If Bolivia had liberalized its water services under GATS, it would have been practically impossible to return these services to public provision.

Many argue that GATS is primarily a mechanism for service sector corporate interests in developed countries to extend their influence into emerging markets around the world. According to Sexton (15), the European Commission, responsible for GATS negotiations in the European Union, considers that GATS is "first and foremost an instrument for the benefit of business, and not only for business in general, but for individual service companies wishing to export services or to invest and operate abroad" (15).

FREER TRADE IN HEALTH CARE SERVICES?

Although the Task Force on Trade report does not deal with liberalization of health services per se, one of the Task Force coordinators recently discussed the direction that health care systems should take in order to achieve the MDGs (20). This author argued that because trade liberalization is already occurring in the health care sector in many countries, "free" trade should be generally promoted. The GATS is seen as a vehicle to facilitate this trade.

The potential risks of privatization linked with GATS and foreign involvement, both in developed (21–22) and developing countries (15, 18, 23), have been already discussed. Privatization can potentially threaten access to health care, quality of care, the presence of skilled health personnel, and public sector financing and policy-making. Recently the UN High Commission on Human Rights summarized the effects of increasing private participation in health services provision under GATS: A two-tier system could lead to specialized surgery responding to profitable areas; "cream skimming," where services are provided to those who can pay more but need less; the "brain drain," with health care professionals moving toward the higher-paying private sector focused on patients who can pay; and possibly diverting resources from rural and primary health care towards specialized centers (24).

Both the Task Force report and the aforementioned discussion by one of the Task Force's coordinators are particularly enthusiastic about Mode 4 of GATS, which deals with movement of persons from one country to another to provide services. In the health sector, the ensuing effect of "brain drain" of health professionals is a particular concern, as noted by the UN High Commission. The movement of trained health professionals from poor to rich countries constitutes wealth transfer, with poor countries subsidizing the health systems of rich countries (who thus do not need to pay for the expensive training of these health personnel). Proponents of Mode 4, such as the Task Force on Trade, cite the funds remitted by workers to their countries of origin. Although it is

true that this occurs, these funds seldom accrue to the health sector. Furthermore, "brain drain" has the potential to paralyze health systems, as has occurred in sub-Saharan Africa. Such undermining of health systems makes the achievement of the health-related MDGs almost impossible.

Overall, the number of sectors in which individual WTO members make commitments within GATS tends to increase with the level of economic development. Nevertheless, no service sector except education has drawn fewer commitments among WTO members than the health sector. The pattern of commitments in health services is mixed. One member, Canada, has not undertaken commitments in any of the four relevant subsectors (medical and dental services; services provided by midwives, nurses, physiotherapists, and paramedical personnel; hospital services; and other human health services such as ambulance services and residential health facility services), Japan and the United States have scheduled only one commitment each, and the European Union, three (14).

The extent of specific commitments by the Latin American countries in relation to individual health services varies. Six countries (Bolivia, Costa Rica, Dominican Republic, Ecuador, Mexico, and Panama) have decided to open up their hospital services. This would facilitate the entrance of foreign health managed-care organizations and investments funds into the health sector of these countries, a trend seen in the Latin American market since the mid-1990s (25). Three countries (Costa Rica, Dominican Republic, and Mexico) have made commitments in the medical and dental services subsector. Only Mexico has committed to openness in the subsector for services provided by midwives, nurses, physiotherapists, and paramedical personnel, and only the Dominican Republic has done likewise in the subsector for other human health services. So far, no commitments have been made by Argentina, Brazil, Chile, Colombia, Cuba, Honduras, Nicaragua, Paraguay, Peru, and Venezuela (26). The comparative reluctance of rich countries to make GATS commitments in the health sector should make poor countries pause before doing so themselves. Even the World Bank has identified this reluctance, as reflected by the tenor of the contributions in its recent publication on GATS and health services (27).

A CALL FOR CAUTION

Latin American countries' progress towards the MDGs has been very uneven. Each country has made different degrees of progress towards different targets (even targets toward the same goal). Overall, although Latin America has made gains towards the target of reducing infant mortality (although progress is very uneven between countries), currently it does not appear likely that the region will meet the targets of reducing maternal mortality and halting the spread of HIV/AIDS (28). It is not possible to identify linear causal pathways for the failures, but the mechanisms and ideology underpinning the various strategies employed in pursuit of the MDGs will be a major factor in the success or failure of the project. Determinants of health are found, to a large extent, outside the health care sector. For example, increased access to drinking water is highly correlated with reduction in infant mortality rates (28). However, health systems also play a major role. Fragmented, privatized health systems are unlikely to favor the achievement of the health-related MDGs. Without access to a strong, universal primary health care system, mothers and children will continue to suffer from avoidable mortality and morbidity. The control of communicable diseases, such as malaria and HIV/AIDS, depends to a great extent on public health goods that fall outside commercial interests, such as preventive services and surveillance (29).

During the past 20 years, international organizations, such as the World Bank and International Monetary Fund, have strongly influenced policy in Latin America, promoting the privatization of health care systems. This is reflected most prominently in the provision of primary and curative services. The emphasis on encouraging privatization by increasing the role of private insurance schemes has led to global insurance companies and managed-care organizations from the United States moving into Latin American markets. This trend would be reinforced by the removal of barriers to the entry of foreign providers, and by the irreversibility of commitments facilitated by GATS. Given the scarcity of data regarding the impact of GATS on health services, and in view of the evidence of the adverse health impacts of privatization in the Latin American context, close monitoring of countries that have made commitments under GATS, and the application of the precautionary principle to avoid further commitments, are recommended. Case studies that aim to link new policies with the level of access to quality health services and to the provision of preventive services in all strata of the population will be essential to evaluate the success of those commitments that have already been negotiated.

Five years after the Millennium Summit in 2000, world leaders met in September 2005 for the 2005 World Summit at the UN in New York to review progress on the MDGs. However, the 2005 Summit outcome document failed to critically evaluate this progress. Again, trade liberalization was endorsed, and no mention was made of the market

failures often experienced in the health care sector, or of the dangers of liberalization of health services to progress towards the MDGs (30). Latin American countries require both trade and international rules to regulate trade, but until now these rules have favored the narrow commercial interests of the most powerful trading nations and multinational corporations. As evidenced by the Task Force on Trade report, it is worrisome that the MDGs are being appropriated in the latest international strategy to promote "free" trade and services liberalization (including health services). Unless genuinely fairer trade is promoted, the beneficiaries of this presumed "free" trade will continue to be those in the developed world who have always profited. This continuing inequity poses a significant threat to population health in Latin America and the achievement of health-related MDGs. It is thus imperative that policymakers consider threats to health in formulating their trade policy in the GATS environment, using tools such as equity-focused health impact assessment (as promoted in the WHO document "Bangkok Charter for Health Promotion in a Globalized World"). This is particularly important if trade is to be a tool, rather than an obstacle, for achieving health-related MDGs in Latin America.

Acknowledgments. We thank the peer reviewers for their helpful comments.

RESUMEN

¿Es la liberación comercial de los servicios la mejor estrategia para alcanzar las Metas de Desarrollo del Milenio relacionadas con la salud en América Latina? Una llamada de alerta

En septiembre de 2000, durante la Cumbre del Milenio de las Naciones Unidas, 147 jefes de estado adoptaron las Metas de Desarrollo del Milenio (MDM) con la intención de reflejar sus compromisos con el desarrollo global y la reducción de la pobreza. En 2002, el Programa para el Desarrollo de las Naciones Unidas estableció el Proyecto del Milenio de las Naciones Unidas, mediante el cual se establecieron 13 grupos de trabajo para identificar estrategias y medios de implementación que permitieran alcanzar cada uno de los objetivos de las MDM. Se creó el Grupo de Estudio sobre el Comercio para la MDM 8, con vistas a desarrollar una asociación global para el desarrollo. El objetivo de este artículo es examinar las principales recomendaciones en política comercial como estrategia para alcanzar las MDM relacionadas con la salud en América Latina. En este artículo se cuestiona la propuesta del informe de ese Grupo de Estudio de promover el "libre" comercio en los países desarrollados y en desarrollo y la liberalización de los servios de salud. También se analizan las implicaciones del Acuerdo General sobre el Comercio de Servicios (AGCS) para los sistemas de salud en América Latina. Se concluye con un llamado de alerta en relación al AGCS y se hace hincapié en la necesidad de un comercio genuinamente más justo para alcanzar las MDM en América Latina.

Palabras clave: comercio, sector de atención de salud, justicia social, América Latina.

REFERENCES

1. United Nations. UN Millennium Development Goals. Available from: http://www.un.org/millenniumgoals/. Accessed 8 February 2006.
2. Sachs JD, McArthur JW. The Millennium Project: a plan for meeting the Millennium Development Goals. Lancet. 2005;365:347–53.
3. UN Millennium Project Task Force on Trade. Trade for development. London: Earthscan; 2005. Available from: http://www.unmillenniumproject.org/documents/TF9-trade-complete.pdf. Accessed 8 February 2006.
4. Interamerican Development Bank. Facing up to inequality in Latin America. Available from: http://www.iadb.org/res/index.cfm?fuseaction=Publications.View&pub_id=B-1998–1999. Accessed 10 February 2006.
5. Weisbrot M, Naiman R, Kim J. The emperor has no growth: declining economic growth rates in the era of globalization. Washington, D.C.: Center for Economic and Policy Research; 2000.
6. Barlow M. The Free Trade Area of the Americas and the threat to social programs, environmental sustainability and social justice in Canada and the Americas. Ottawa: The Council of Canadians; 2001. Available from: http://www.canadians.org. Accessed 12 February 2006.
7. Kanji N, Barrientos S. Trade liberalization, poverty and livelihoods: understanding the linkages. Brighton: International Institute for Environment and Development; 2002.
8. Oxfam. Rigged rules and double standards: trade, globalization and the fight against poverty. Available from: http://www.maketradefair.com/en/index.php?file=0304200 2121618.htm. Accessed 12 February 2006.
9. Labonte R. Dying for trade: why globalization can be bad for our health. Toronto: The CSJ Foundation for Research and Education; 2003. Available from: http://www.socialjustice.org. Accessed 12 February 2006.
10. Spiegel JM, Labonte R, Ostry AS. Understanding 'globalization' as a determinant of health determinants: a critical perspective. Int J Occup Environ Health. 2004;10(4):360–7.
11. Homedes N, Ugalde A. Why neoliberal health reforms have failed in Latin America. Health Policy. 2005;71(1): 83–96.
12. Machinea JL, Bárcena A, León A. The Millenium Development Goals: a Latin American perspective. Santiago de Chile: United Nations; 2005.
13. World Trade Organization. An introduction to the GATS. Available from: http://www.wto.org/english/tratop_e/serv_e/gsintr_e.doc. Accessed 13 February 2006.
14. Adlung R, Carzaniga A. Health services under the General Agreement on Trade in Services. Bull World Health Organ. 2001;79(4):352–64.
15. Sexton S. Trading health care away? GATS, public services and privatization. Available from: htpp://www. the corner house.org.uk/briefing/index. shtml. Accessed 12 February 2006.

16. Grynberg R, Ognivtsev V, Razzaque MA. Paying the price for joining the WTO: a comparative assessment of services sector commitments by WTO members and acceding countries. London: Commonwealth Secretariat; 2003.
17. GATSwatch. GATS requests and offers. Available from: http://www.gatswatch.org/requests-offers.html. Accessed 12 February 2006.
18. Timmermans K. Developing countries and trade in health services: which way is forward? Int J Health Serv. 2004;34(3):453–66.
19. Public Citizen. Water privatization case study: Cochabamba, Bolivia. Washington, D.C.: Public Citizen; 2001. Available from: http://www.citizen.org/documents/Bolivia _(PDF). Accessed 15 February 2006.
20. Messerlin PA. Trade, drugs, and health-care services. Lancet. 2005;365:1198–200.
21. Shaffer ER, Waitzkin H, Brenner J, Jasso-Aguilar R. Global trade and public health. Am J Public Health. 2005; 95(1):23–34.
22. Pollock AM, Price D. The public health implications of world trade negotiations on the general agreement on trade in services and public services. Lancet. 2003;362:1072–5.
23. Wibulpolprasert S, Pachanee CA, Pitayarangsarit S, Hempisut P. International service trade and its implications for human resources for health: a case study of Thailand. Hum Resour Health. 2004; 2(1):10.
24. United Nations. Commission on Human Rights. Report of the High Commissioner. Liberalization of trade in services and human rights, 2002. Available from: http://www.unhchr.ch/Huridocda/Huridoca.nsf/(Symbol)/ E.CN.4.Sub.2.2002.9.En?Opendocument. Accessed 13 February 2006.
25. Iriart C, Merhy EE, Waitzkin H. Managed care in Latin America: the new common sense in health policy reform. Soc Sci Med. 2001;52(8):1243–53.
26. Adlung R, Carzaniga A. Update on GATS commitments and negotiations. In: Blouin C, Drager N, Smith R, eds. International trade in health services and the GATS. Washington DC: World Bank; 2006. Pp. 84–5.
27. Blouin C, Drager N, Smith R, eds. International trade in health services and the GATS. Washington, D.C.: World Bank; 2006.
28. Machinea JL, Bárcena A, León A. The Millenium Development Goals: a Latin American perspective. Santiago de Chile: United Nations; 2005.
29. Kaul I. Faust M. Global public good and health: taking the agenda forward. Bull World Health Organ. 2001;79:869–74.
30. United Nations. The 2005 World Summit outcome. Available from: http://www.un. org/summit2005/documents.html. Accessed 15 February 2006.

Conference on Social, Cultural, and Economic Determinants of Public Health

Dates: 9–11 May 2007
Location: SANA Lisboa Hotel
Lisbon, Portugal

The first international conference of the journal *Public Health* will be a major, international, multidisciplinary and intersectoral event that will review current knowledge of social, cultural, and economic determinants of health, and how such determinants can be influenced to improve public health.

The main themes of the conference will include social and societal factors in health and the reduction in health inequalities; culture, lifestyle, and choice in health and well-being; the economics of public health and health care delivery; and systems change for health improvement.

If paid by 16 March, the fee to attend the conference is € 477.95 (about US$ 627). After that date, the fee is € 532.40 (about US$ 699).

Information:

Tracy Collier,
Public Health Conference Secretariat
47 Red House Road
Bodicote, Banbury
Oxon OX15 4AZ, United Kingdom
Fax: 44 (0) 1295 253334
Web site: http://www.publichealth.elsevier.com/index.htm