Trading in Africans' health

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The image of a Kenyan patient, chained to a hospital bed until his bill has been settled, is a shocking indictment of the failed economic prescription of the developed world. Today events are unfolding that could ensnare Africans' health in a Western economic straitjacket. Agreements, summits and directives flow from a host of organisations dedicated to free market principles, the World Trade Organisation (WTO), the International Monetary Fund (IMF), and the European Union (EU). All bring a conviction that a global free market in services, can ensure Africans' health. The evidence from non governmental organisations campaigning for the right to health, such as Wemos in the Netherlands, could not be further from the truth.

Until 1989 Kenyans received free health care. Then, under pressure from the IMF and the World Bank to reduce government debt, hospital user fees were introduced and uninsured patients required to make out of pocket payments. Today even the subsidised general wing of Nairobi's national hospital charges almost US$4 a day. This is beyond the reach of Kenya's overwhelmingly rural population, half of whom live below the poverty line living on just US$1 a day.

Privatised health care

Public services have largely collapsed leaving just one doctor between 33,000 people in rural Kenya. By contrast private hospitals located in the cities with no commitment to treat poor or uninsured patients thrive attracting wealthy foreign patients and the best doctors. Here there is one doctor for every 1,700 people. Wemos working with local consumer groups has uncovered evidence that some foreign-owned private hospitals may discharge patients before treatment is completed if they cannot pay. Others may be forced to work in the hospital gardens or kitchens in lieu of payment or chained to their beds until they can raise the cash.
Yet it is precisely these foreign-owned private hospitals that would benefit from the current international trade negotiations conducted through the 147 countries belonging to the World Trade Organisation. Since 2000 negotiations have been underway to extend the liberalisation of services under the General Agreement on Trade in Services (GATS) to include essential services such as health care.

Talks are continuing this autumn and Kenya has yet to agree. Wemos and others are reminding governments of their legal commitments, so far ignored, to first assess the impact on developing countries of such trade liberalisation.
Meanwhile GATS has already made inroads. Kenya agreed to liberalise its financial services failing to realise this included health insurance. Had it known it could have required foreign insurers to insure poor patients or those who are HIV positive. Now under GATS rules it can only do this if it requires Kenyan-based insurers to do the same.
So wealthy, healthy urban Kenyans buy foreign commercial health insurance while the government's public heath insurance is forced to accept all patients

especially those who suffer from HIV/AIDS. Thus there is no sharing of risk and the quality of public insurance declines.

The EU directive on Internal Market

The European Union meanwhile is set to liberalise trade in services further with its new EU draft directive or law, "Services in the Internal Market". This would establish the principle that private companies need only comply with the rules of the EU country where they are "established" or based, and not to the rules of the EU-country where they operate. This might be very attractive from a competition and profit point of view, but undermines social rights and labour standards. For example, a nurse hired by a Dutch hospital via a Polish temp agency, will not even receive a Dutch minimum wage .Wemos fears, once the law is approved, the private sector will pressure the EU even further to apply this principle internationally, for example in the context of GATS negotiations. Therefore, this precedent could have dangerous consequences for Africa. It could erode the independent authority of African governments to protect its people's right to health.

GATS promoting free trade in services endangers African's health further by stimulating an exodus of desperately needed trained doctors and nurses. The last decade has seen this trend accelerate as staff is tempted by better wages and opportunities to work in hospitals in the United States or the United Kingdom.

African governments may be seduced by the short term prospects of foreign currency earnings; but in the long term it spells disaster with fewer staff, clinics and care.
For while the Netherlands enjoys a ratio of one doctor to every 2,000 patients many African countries such as Mozambique, Malawi, and Tanzania struggle with just one in 30,000.
Ironically Africa has a strong tradition of medical training. But countries such as Ghana lost 60% of its medical trainees in the decade to 1996 while Nigeria has since 1990 lost 21,000 doctors, which cost it US$420 million to train. With the implementation of GATS, this trend will be further aggravated.

Health for all

Wemos reminds politicians and government of their obligation to promote the right to health care enshrined in the Universal Declaration of Human Rights and the UN's Treaty on the Rights of the Child. Wemos also highlights the effect of trade on health in developing countries during the week of international health starting on 22 November 2004. It is calling on health care staff and institutions in the Netherlands to declare their solidarity by sending a SMS with the word SOS to 4777.

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