

## **The Commodification of the Right to Health**

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Within weeks of the first few confirmed deaths caused by the H1N1 flu, it was declared a global pandemic, and just as quickly in the U.S. and Canada, a vaccine was developed and distributed en masse. The global crisis of the H1N1 flu brought to our attention the interesting relationship between globalization and the access to health care globally. Globalization, or the interconnectedness of the world's markets, laws, and cultures, and its affect on health care, provides us a glimpse into the adverse relationship of health in developed and developing countries (Fidler 191). Unfortunately, developing countries, particularly those in Africa, entered the era of globalization with far worse health conditions than those in the developed world. As a result, in 1978 the World Health Organization (WHO) and UNICEF announced the Alma-Ata Declaration, which declared the goal of providing the human right to health for all by the year 2000 (Aginam 619). However, the Alma-Ata Declaration has not been reached, and directly at fault for this failure are the processes of globalization. This paper will argue that the failure of providing health care to those living in the developing world, especially in Africa, is because of the promotion of global governance modalities like the IMF, World Bank, and the WTO, which prevents developing countries from providing health care to its people for the advancement of the global capitalistic market and transnational corporations.

This paper will make this argument by examining the current health conditions of developing states. This will be followed by an analysis of the good governance agenda that Western nations believe will help improve health conditions around the world. I will then look at how the good governance agenda places greater importance on civil and political rights as

opposed to economic and social rights, such as the right to health. Next, I will analyze the impact of Structural Adjustment Programmes (SAPs) on the ability of developing nations to provide health care. I will also look at the WTO and its promotion of trade liberalization, and its impact on the quality of health care. As well, I will look at the WTO's enforcement of patent protection, which causes new drugs to become too expensive for most people in developing countries to afford. Also, I will look at the how developing countries try to avoid paying high prices for essential drugs through the use of compulsory licenses. Finally, I will examine recent developments to improve access to health care, such as the Doha Declaration, which actually fails to provide real solutions to the issue of access to health care. However, I begin by discussing the development of ensuring health as a basic human right.

The proclamation that all humans have the fundamental human right to health was first declared by WHO in 1946, when it claimed that all humans should enjoy the highest standard of health, which was later expressed through programs like the Alma-Ata Declaration (Torres 105). This "second generation" human right is legally recognized by the majority of UN members under the International Covenant on Economic, Social, and Cultural Rights (ICESCR). Signatories of the ICESCR recognize that to ensure that all humans have the right to health, many measures are to be taken, but none more important than preventing and controlling diseases by assuring equal access to medical care for all (Torres 107).

However, the widening gap in health conditions between developed and developing countries is becoming worse. In North America and Europe, people affected with infectious diseases like HIV/AIDS are living longer and healthier lives because of the accessibility of antiretroviral treatment (Geffen 497). However, infectious diseases kill over ten million people every year, and over 90% of those affected live in the developing world, where HIV/AIDS,

respiratory infections, malaria, and tuberculosis are leading causes of deaths (Hoen, 2002: 27). In fact, it is estimated that in the developing world, 8000 people die each day from HIV/AIDS (Hoen, 2002: 27). To alleviate the health gap, many non-governmental organizations (NGOs) have campaigned to increase the access to medical therapies in developing countries, so that they may treat infectious diseases, as is done in North America and Europe, where HIV/AIDS has become a managed chronic disease (Torres 105). Nonetheless, 95% of those in the developing world affected by infectious diseases are not able to afford medical treatment (Elliot). The question many are left asking is how could the developing world increase its access to health care to improve the health of its people?

One solution offered was the good governance model. The good governance model suggests that the developing world, especially Sub-Saharan Africa, have been weakened in the international trading system because of strict economic regulations at the domestic level (Gathii 1016). Africa's policies of reliance on commodity exports, protectionist import policies, price controls and overall economic regulations, have led it to become marginalized in the global market (Fidler 202). Moreover, the lack of economic development is partly to blame for Africa's inadequate access to health care (Fidler 202). However, the good governance agenda sets out to encourage developing countries to adopt policies as promoted by neo-liberal globalism. Based on the "Washington Consensus", the good governance agenda stipulates developing countries must liberalize their economies, by engaging in international trade, eliminating subsidies, increasing privatization, and protecting property rights (Abouharb 63). It is argued that this focus on economic development would reduce poverty in the developing world, which would in turn allow governments to invest more in their health care systems (Fidler 214).

The good governance agenda is promoted through global governance modalities like the International Monetary Fund (IMF), the World Bank, and the World Trade Organization (WTO). Since 1981, the IMF and World Bank, under the influence of Reagan and Thatcher, have promoted the Washington Consensus through structural adjustment programs (SAPs) (Abouharb 15). The IMF and World Bank use SAPs to completely overhaul a country's economy. In exchange for receiving loans to service its debts, a country must undertake a structural adjustment of its economy through a process that includes removing barriers to trade, deregulating the economy, reducing budget expenditures, and increasing foreign investment (Fidler 204). The adoption of SAPs would improve the economic development of a developing country and assist its integration with the global market. A key element to this integration is the WTO. Established in 1995, the purpose of the WTO is to facilitate the liberalization and removal of barriers to trade by promoting the free movement of labour, capital, goods and services, along with the respect for intellectual property rights (Price 55). A general principle of the WTO is that members must accept all trade agreements as a package deal, must not discriminate between trading partners, and must harmonize trading policies with the global market (Mirza 93).

However, the focus on economic liberalization has in fact restricted the role developing countries can play in increasing access to health care to its people. In terms of ideology, the good governance agenda is more inclined to place greater importance on civil and political rights over economic and social rights. As argued earlier, the U.S. and its allies began promoting the good governance agenda of economic liberalization. Along with this promotion, the U.S. has supported the idea of political liberalization as expressed in the International Covenant on Civil and Political Rights (ICCPR), which promotes such rights like the right to self-determination, the right to a fair trial, freedom of expression and freedom of religion (Callaway 6). It is argued that

political freedom is necessary for citizens to have an opinion on what types of economic policies their governments should adopt (Gathii 1023). Moreover, the political freedoms expressed in the ICCPR are referred to as negative rights because they require the government to refrain from interfering with the political liberties of its citizens, which in fact corresponds with the good governance agenda of eliminating government involvement in the economy (Gathii 1024). However, the right to health as promoted under the ICESCR is a positive right, which actually requires the state to take action in providing an adequate standard of living for its people (Callaway 7). In regards to the right to health, a government must ensure it provides its populace with an accessible and adequate health care system. Unfortunately, economic, social, and cultural rights are deemed inferior to civil and political rights by developed nations in their promotion of good governance. For example, the rights under the ICCPR are referred to as first generation rights, and thus are considered as being superior to second generation rights under ICESCR, including the right to health (Aginam 614). Consequently, the IMF and World Bank have heavily promoted this false idea of subordination.

The IMF and World Bank have argued that SAPs have in fact stabilized the economies of developing nations, which has allowed them to repay their debt (Aginam 621). However, there is a great cost to the economic restructuring these countries are required to undertake. The conditions promoted through SAPs forces developing countries to drastically reduce expenditures in the health care sector in return for receiving loans (Fidler 205). For example, developing states undertake certain types of projects deemed necessary for economic growth, such as the building of dams, roads, railways, and commercial farming land (Callaway 248). Inevitably, social programs like health care are sacrificed. To reduce government expenses, developing countries would eliminate subsidies in the health care sector, and would instead

impose user fees, even though most patients are unable to afford it (Fidler 205). A consequence of eliminating subsidies is a dramatic reduction in health care quality and access (Fidler 205). In fact, many developing countries that have adopted SAPs, have seen increases in infectious diseases. For instance, Costa Rica implemented SAPs in 1981 and reduced its investment in the health care sector. As a result, in 1985 the Ministry of Health reported an increase in infectious diseases (Abouharb 139). Economist Michel Chossudovsky refers to this development as a form of “market colonialism”, in reference to a new form of economic domination (Aginam 621). The IMF and World Bank are more concerned about financial profits for banks and transnational corporations (TNCs) located in developed states than social development of developing states (Callaway 249). Unfortunately, developing states are pressured into adopting policies that will attract foreign investment and trade, and to do so they must sacrifice social and economic priorities, like health care, which should be more of a concern than increasing the profits of external agents and satisfying the global market (Fidler 206).

As mentioned earlier, the WTO plays a central role in facilitating the foreign investment and trade that is promoted by the IMF and World Bank under the guise of “good governance”. The General Agreement on Trade in Services (GATS) is an important international agreement that all WTO members must follow in their effort to liberalize international trade. GATS is an international agreement that stipulates WTO members to eliminate any barriers to trade, and is not restricted to border controls like tariffs, but also targets any laws, requirements, practices, procedures, or “any other form” that regulates trade in goods and services (Price 55). In fact, one of the consequences of this trade liberalization is that developing countries see a fall in budget revenue because of the loss of revenue from trade taxes, which essentially accounts for a loss of one-third of all budget revenue in most countries (Abouharb 142). As a result, in an attempt to

repay budget deficits, these counties must cut back spending in public services like health care (Abouharb 142). Consequently, health care policies are reformed to accommodate the private sector.

Yet, as restrictive as these measures have been in providing health care to people of developing countries, none are more detrimental than the agreement on Trade-Related Aspects of Intellectual Property (TRIPS). With over 90% of those affected by infectious diseases living in the developing world, the cost of receiving therapy is far too expensive because of contrary restrictions imposed by WTO. TRIPS, which is managed by the WTO, does not advance trade liberalization, but in fact restricts trade in the pharmaceutical industry (Elliot). TRIPS monopolizes the pharmaceutical industry by regulating the standards of the industry in regards to patent protection. Under TRIPS, patents for inventions, including both the product and the process, is to be respected for a minimum of twenty years (Sykes 3). In terms of the pharmaceutical industry, article 28 of TRIPS awards to a corporation the exclusive right to make, use, and sale its patented product or process (Sykes 3). Moreover, signatories to TRIPS agree to the principles of “national treatment” and “most favoured nation treatment”, which means that it is illegal for a country to discriminate between local or foreign companies or countries (Mirza 93). Not surprisingly, 97% of the patents are held by individuals and companies belonging to the developed world (Hoen, 2002: 37).

Critics of TRIPS argue that these patent protections are for the sole purpose of securing profits for corporations. While not refuted, pharmaceutical executives contend that seeking profits can be justified. They claim that the cost of investing in research and development of new medicines is extremely expensive (Elliot). Thus, these companies need strong patent protection to ensure a greater return on their investment. However, this argument is weak for several

reasons. Firstly, much of the costs these companies are “burdened” with are financed by public research funds, and a portion of it is used on advertising new drugs (Elliot). Also, pharmaceutical companies do not disclose the actual costs of research and development (R&D), so information that is reported can be unreliable. For example, various reports state that the cost of R&D on a single drug can vary from \$1 to \$200 million (Hoen, 1999: 90). On the other hand, the profits these drugs generate for companies are much greater than any estimates of the cost of R&D. For example, pharmaceutical company Glaxco Wellcome made \$589 million in one year on one AIDS drug that will be protected by patents and sold for over twenty years (Elliot).

Nevertheless, the impact that TRIPS has had on the cost of purchasing drugs cannot be disputed. For example, 150mg of the HIV drug fluconazole costs \$55 in India, where the drug is not patented. However, the same drug costs \$697 in Malaysia, \$703 in Indonesia, and \$817 in the Philippines, where the drug is patented (Sykes 1). Moreover, the HIV treatment AZT costs \$48 per month in India, but costs \$239 per month in the U.S., where it is patent protected (Sykes 1). While most people in the U.S. can afford to pay \$239 per month, such prices far exceed what most people in the developing world can afford to pay. As a result, most people would have no option but to wait twenty years until the patent has expired and generic drugs can be produced (Mirza 94). In fact, WHO in 1985 reported that 75% of the world’s population living in developing countries consumed only 11% of available drugs (Mirza 93). So while the U.S. makes up 33% of the global market share in pharmaceuticals, Africa accounts for only 1.8% (Mirza 93). However, since these companies are seeking a profit, most tend to develop and market drugs that are intended for developed countries (Elliot). The casualty of this capitalistic focus of health care is that these companies eventually discontinue the production of some essential drugs needed in the developing world. For instance, Merrell Dow discontinued the



production of the drug DMFO in the early 1990s for a lack of “commercial opportunities”, which is used to treat the deadly disease “sleeping sickness” that affects 30,000 people in Africa, (Hoen, 1999: 88). In fact, between 1975 and 1997, 1223 new drugs were produced, out of which only thirteen treated tropical diseases (Mirza 95). On a side note, of those thirteen, only four were directly developed through research. Yet, as stated by the European Directorate General for Trade, “no priority should be given to health over intellectual property considerations” (Hoen, 2002: 36).

Nonetheless, governments of developing countries are becoming increasingly assertive in criticizing the structure of the trading system and are discovering solutions through legal channels. One such solution is the use of compulsory licensing, which is outlined in Article 31 of TRIPS that states a country is allowed to issue licenses to local companies to manufacture generic versions of expensive and patented drugs, but with the condition that a small royalty must be paid to the patent holder (Fidler 211). Nevertheless, these generic drugs remain much more affordable for people in developing countries to purchase than protected drugs.

However, many feel compulsory licensing as stated in TRIPS is ambiguous and so many developing countries are reluctant to use it in fear that developed states or pharmaceutical companies will take action against its use (Geffen 498). As was the case in South Africa, in which the government was pressured by the U.S. to not continue its use of compulsory licenses for the production of HIV/AIDS drugs (Fidler 211). In 1998, when the South African government ignored the demands, dozens of pharmaceutical companies and organizations alleged it had violated TRIPS by issuing compulsory licenses and took the government to court (Hoen, 2002: 30). In fact, the U.S. and the European Commission (EU) placed trade sanctions against South Africa. However, increasing public pressure and protests forced the U.S. and EU to

drop their demands, which was followed by the pharmaceutical companies dropping their case (Hoen, 2002: 30).

Nevertheless, developing countries believed certain clarifications needed to be made in regards to TRIPS and compulsory licenses, so that cases like South Africa would not be repeated. Thus, during the fourth WTO ministerial meetings in Doha, a legal declaration was agreed upon. The 2001 Declaration on the TRIPS Agreement and Public Health (Doha Declaration) clarified that TRIPS should not interfere with a country's ability to provide access to health care to its public, especially those most affected by infectious diseases like HIV/AIDS (Sykes 5). Moreover, each government has the right to issue compulsory licenses, especially in cases of national emergency or other public health crises that are solely determined by that government only (Sykes 5).

Unfortunately, the Doha declaration has severe shortfalls. Critics have even questioned the process that was taken to reach the declaration. Firstly, Qatar is a monarchy and thus it was able to limit public protests (Bello 275). As made clear in Seattle and South Africa, public protests can play an important role in political discussions. However, Qatar decided to authorize the WTO to grant entry visas, which allowed it to restrict the amount of NGOs accepted into the country (Bello 275). Moreover, reports state that Western nations used unfair tactics to force compliance on the part of developing states. For example, the U.S. notified the representatives of Haiti and the Dominican Republic that if they did not comply with U.S. demands, it would abandon any favourable trade agreements it has with both countries (Bello 275). On the other hand, the EU offered preferential trade agreements for agricultural commodities to states from Africa and the Caribbean, in return for approving the final declaration. Lastly, Nigeria was offered a favourable economic and military aid package by the U.S., in return for abandoning its

position of denouncing the declaration. As a result of these tactics, the Doha Declaration was signed by all members despite its clear weaknesses.

For one, many developing states wanted some additions to TRIPS. They wanted to clarify that they have the right to grant compulsory licenses to foreign states or companies because many countries do not have the technical ability to produce drugs (Sykes 5). However, no such clarifications were made, and so most developing countries are only able to use compulsory licenses for domestic productions. Moreover, the claim that the TRIPS agreement must not interfere with measures to protect public health is simply a political statement and is not legally binding on members (Bello 274). Thus, there are no legal stipulations in the Doha Declaration for developed states or pharmaceutical companies to follow, allowing them in the future to take developing states to court over any disagreements (Bello 274). Unfortunately, the Doha Declaration does not offer any substantial changes or solutions to TRIPS, but only preserves the misguided principle that profits come before health.

In conclusion, this paper argued that through global governance modalities like the IMF, World Bank, and the WTO, the ability of providing the human right to health is disregarded by developed countries in favour for market considerations or simply profit. This paper made this argument by examining the effects of the good governance agenda, the importance placed on civil and political rights, the promotion of SAPs, the patent regulations enforced by the WTO, and the questionable impact of the Doha Declaration. As made clear above, viable solutions are hard to come by when there are such clear oppositions to reaching one. However, what is clear is that pressure from the public makes a difference. Thus, there needs to be a continued effort to protest, so that we may ensure that public health will never be sacrificed for private profit.

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