DPAR

Main Identity

From: "Naveen" <navthom@yahoo.co.uk>
To: "Community Health Cell" <sochara@vsnl.com>
Sent: Thursday, February 19, 2004 6:51 PM
Subject: Patent battle: Uproar over sale of Indian drug in US

Patent battle: Uproar over sale of Indian drug in US

Gilvester

Wednesday, February 18, 2004 (Thiruvananthapuram):

A medicine could soon become a test case for a patent battle between India and the United States.

A Kerala government institute, which holds the Indian patent for the anti-fatigue drug, Jeevani has discovered that a US company, NutriScience was already selling it in America.

The Tropical Botanic Garden Research institute insists that the move is illegal.

"All this reflects to a fact that people have just cashed on the fame of *Jeevani* and tried to put something, which may not be exactly *Jeevani*," said G M Nair, Director, Tropical Botanic Garden Research Institute.

Two per cent cut

The institute was getting a two per cent commission from a Coimbatore based pharmacy licenced to manufacture *Jeevani*.

TH 29/2

Officials add that ideally the US company, which was selling the drug at 12 times more than the Indian cost, should also be paying a 2 per cent fee to the Kerala Institute.

And according to officials the fact that the US company is not paying the prescribed amount, is a blatant violation of intellectual property rights.

Legal action

There is also the big question as to how the US firm procured the required herb *Arogyapacha*. This herb only grows in the Western Ghats.

Kerala government officials say this is a serious violation of the Biological Diversity Act.

"This act prevents taking away biological species in whatever form from one country to another," said Dr KRS Krishnan, Director, Kerala Science and Technology Department.

The American company's website however, claims to have rights to sell the drug. But the institute is still considering legal action on three counts, namely misuse of a trademark and manufacturing and using the formulation without its consent.

http://www.ndtv.com/

CHC lib file – drug patents / TRIPS
SN 23/2

2/20/04

GLOBALIZATION

Refers to a set of economic and political policies that believes in taking down all the barriers to creation of a single global market as the best prescription for prosperity

LIBERALIZATION

A political policy where state controls over production and trade are removed
Or decreased considerably. Market is the better judge of people's needs than the government.

PRIVATIZATION

This is policy by which a government hands over all public sector undertakings and services provided by it to private hands.

INTERNATIONAL MONETARY FUND

INTERNATIONAL MONETARY FUND

An international financial institution floated by the powerful countries of the west to manage international financial situation.

WORLD TRADE ORGANIZATION (WTO)

This is an international body composed of all the nations of the world who have signed international trade agreement (most of which are against the interest of developing countries)

WORLD BANK

This is an international bank whose larges shareholders (and therefore effective owners) are rich nations of the world mainly the USA.

MULTINATIONAL CORPORATIONS

These large companies span many countries & continents. Most of them have huge assets often more than the total budgets of many poor countries put together. They do not come under any one country's laws.

STRUCTURAL ADJSUTMENT PROGRAME

The IMF and World Bank impose these policies on indebted nations as a condition for deferring their loan repayment for giving them fresh loan.

Globalization its effects on women

- ↑ Women work force in informal
  - » Unorganized sectors
  - » Lack of social security
- ↑ Commodification of women
- ↑ Violence & crime against women
- ↑ Rising cost of health care
  - ↑ Home care
  - ↑ Work for women
- ↓ State Government subsidy to Health
- ↑ Glorification of technology
- ↓ Primary Health Care

- ↓ Preventive and Promotive Care

- ↓ Role of international / donor agencies in policy

GC-5

737 A8 f

Subject: Re: reader on Globalisation and health
Date: Thu, 24 Oct 2002 17:33:57 +0530
From: Community Health Cell <sochara@vsnl.com>
To: wulf@medico.de, Wulf@medico.de

Dear Andreas,

Greetings from Community Health Cell / Peoples Health Movement, Bangalore!

It was nice to hear from you after a long time. We did not receive your earlier letter of 3/7/2002 and hence were surprised at the silence. Hope you received the thank you letter we sent to all of you in Europe as well as the PHM Geneva reports. There was no acknowledgements so we were wondering what happened? Glad to be in touch again.

1. We both will be very glad to participate in your effort and will try and send the contribution on Indian PHM - "From Bhopal to JSA - the CHC experience" the title. Jana Swasthya Abhiyan is the Indian name for PHM. Hope to keep the deadline.
2. Three recent developments / events which will be of interest to you all.

a) Thelma and I are doing a PHM - India - East Africa solidarity initiative which involves meetings in Nairobi (4th to 5th November); Kampala (6th to 7th November); Dar-es-Salam (8th to 9th November) and Arusha (11th November). A separate not is being forwarded to you. Please send it to any Medicos International Contacts in these four cities of Konya, Uganda and Tanzania.
b) From 12th to 15th November, we both join David Sanders and Zafarullah Chowdhury in a PHM input into Forum 6 - Global Forum for Health Research at Arusha, Tanzania organized by GFHR / WHO. If you know anyone from Germany who is attending Forum 6, please alert them to make contact with us.
c) From 20th to 23rd November, I attend the PHM core group meeting in GK-Savar, Bangladesh where there is a strong possibility that CHC will take over as coordinator of the PHM International secretariat and take it to Bangalore. We hope to keep closer touch with PHM-Germany from then (!).
d) From 2nd to 7th January at Hyderabad, India, a large PHM like event is being organized - The Asia Social Forum which is a precursor event to World Social Forum in Brazil (Porte Allegre) at the end of January. PHM - India and Asia will be organizing many seminars, workshops and we are part of a large intersectoral collective of civil society and campaigns. It will be a very informative, interactive opportunity. If PHM - Germany or Medico are keen to send some one in solidarity, please do so. You will get a lot of information and contacts about the Asian situation and Asian movement in a 5 day capsule - very very cost effective. Over 10000 people are expected for the celebration. I shall mark some materials to you. Everyone is paying for their own travel to Hyderabad. Very low cost boarding and lodging facilities will be available. It will be like a mega-BUKO conference!

Our best wishes to Thomas, Jutta, Christiane and all the others.

Yours sincerely,

Ravi & Tholma Narayan
CHC / PHM

To TN for information → & Andreas Letter
25/10

WSF Brouchurefinal3-10.doc	**Name:** WSF Brouchurefinal3-10.doc **Type:** Winword File (application/msword) **Encoding:** base64

East Africa Visit - Final Note.doc	**Name:** East Africa Visit - Final Note.doc **Type:** Winword File (application/msword) **Encoding:** base64

Subject: Fw: reader on Globalisation and health
Date: Thu, 17 Oct 2002 11:26:42 +0200
From: "Andreas Wulf" <Wulf@medico.de>
To: <sochara@vsnl.com>

Dear Thelma and Ravi,

may I remind you on our request we sent to you some time ago (see below) and ask if we can still count on you for a contribution to this report? we would be very happy to use this as a lobby tool in Germany for 25 anniversary of Alma Ata. We extended the deadline for articles until 1 of December - do you think this would be feasible for you? Thank you very much for your help
Best regards
Andreas

----- Original Message -----
From: Andreas Wulf
To: sochara@vsnl.com
Cc: Thomas Seibert
Sent: Wednesday, July 03, 2002 7:31 PM
Subject: reader on Globalisation and health

Dear Thelma and Ravi,

I hope you are all fine and had a good trip back to Bangalore after the Geneva meeting. sorry for not keeping in touch the last day to say good bye.
Right now, we here in medico are busy to prepare some kind of background reader/booklet (around 130 pages) for our health campaign with some basic analysis on Globalisation and its impact on Health and Health Care Systems, the PHC-Concept and some experiences from countries and projects and presenting the ongoing campaigns around this topics -
and we hope we can win some of the PHM-people to contribute to this work so it would reflect some broad spectrum of whats going on (and what had going on) in this field of struggle.

So may we ask you to participate in this work? We would be very happy to have an article on the Indian Health movement in this booklet, as we were very impressed by your brief but thorough presentation you gave us during our short talk together with Thomas and Jutta at the BUKO-Conference in Frankfurt. We would like to put it into the section on PHC-Concepts - Experiences - Movements as you can see it in the document attached. (I translated only the headlines to give you an idea of the report) We think of a not too long paper with around 12.500 letters (5 pages) that might span the time from the 70ths up to now (from Bophal to the CHC).

Please don't hesitate to ask for more details I might have forgotten right now.

Hoping to hear from you soon and thank you very much in advance

Best regards

Andreas Wulf

TN for remarks / response
RN 16/10

new e-mail!
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Entered in Address Diary

Reply → P. To

Concept report.rtf
Name: Concept report.rtf
Type: Winword File (application/msword)
Encoding: quoted-printable

RN 17/10/02

Concept: medico international Report on Globalisation and Health

Editorial: Globalisation and Critique: The example Health and Health Care
Medico's concept and project of health
Gesundheit ist mehr als die Abwesenheit von Krankheit.
Gesundheit ist nicht das Gegenteil von Krankheit.
Qualitativer Gesundheitsbegriff. Gesundheit keine Frage von Medikamenten und medizinischer Hilfe, sondern eines Lebens in Gesundheit. Was "gesund" ist, bestimmen die Betroffenen, nicht die Experten. Gesellschaftliche Garantie des Zugangs zu Gesundheit einerseits – Partizipation und Selbstorganisation andererseits. Die Gefahr der Bürokratie einerseits und eines kommunitären "Neoliberalismus von unten" andererseits: Wo ist Staatlichkeit notwendig, wo Selbstorganisation möglich?
Kampf für das Recht auf Gesundheit. medico als Knotenpunkt einer globalisierungskritischen Weltgesundheitsbewegung: ÖA und PA: Projekte, Netze & Campaigning – ein Artikel zum Selbstverständnis und Hinweis auf den Schlußartikel (Thomas/Andreas; 5 S., 12.500 Zeichen)

1.) Conditions, Analysis, Backgrounds

1. 1.) Globalisation and Health – The subject perspective

Globalisierung als Prozess der Freisetzung von Kapital, Waren, Arbeit, Wissen, Dienstleistung - und, freiwillig wie gezwungen - von Menschen.
HIV/AIDS als Krankheit des "mobilsten"/"flexibilisiertesten" Teils der global "Freigesetzten": "Mister 0, der schwule Flugbegleiter"
Metropolitan als Krankheit zuerst der homosexuellen und drogengebrauchenden Subkulturen - freigesetzt aus bürgerlich-heterosexueller Familientradition, aus fortpflanzungszentrierter Sexualität, aus traditioneller Sittlichkeit, aus Sozialen Sicherungen etc.
Peripher als Krankheit der aus ihrer ländlichen Herkunft, aber auch aus aller urbanen Erwerbslebensperspektive und natürlich ebenfalls aus der traditionellen Sittlichkeit "freigesetzten" township- und favela-Jugend und als Krankheit der globalen Arbeitsmigration (tatsächlich zentral für die Verbeitung, im Süden die Migration ins südliche Afrika, sowie natürlich über alle Süd-Nord-Routen.
Die "Seuchen"-form als Problemanzeige.
Die systematische Ungleichheit der Heilungschancen
Die Repressivität im Umgang mit der Erkrankung: gegen die "Freisetzung" eine repressive "Rekonstruktion des Sozialen"
Einsatz: was wäre dem gegenüber ein anderer Umgang - mit der Krankheit, aber auch mit der für sie ursächlichen "Freisetzung": ergo: was wäre eine emanzipative "Rekonstruktion des Sozialen" als Bedingung von Heilung und Gesundung
(Andreas und Thomas S.; 8 S., 20.000 Zeichen)

1. 2.) Globalisation and Health – perspectives of economy and power (2 Artikel)
1. 2. 1. **WTO, GATS**, Commodification, Privatisation of Health, Health as a Commodity
Medizinal-pharmazeutischer Komplex: Medikalisierung des Lebens, die ganze Palette, "Massenkrankheiten der Armut", wiederum HIV/AIDS als Fokus: alles, was

im AIDS-respect-Heft schon zur Sprache kam. **(Heiko Wegmann, Thomas Fritz;** 5 S., 12.500 Zeichen)

1. **2. 2. WTO and TRIPS: Patents and Profits, Access to Healthcare**

. aber auch, wenn der Zugang zu Medikamenten & ärztlichen Einrichtungen gesichert wäre, der Zugang zu gesundheitsfördernden Lebensbedingungen: Erwerb/Einkommen, Hygiene, Wohnung, Lebensmittel, aber auch Partizipation an Bildung, Wissen, Rechten, TRIPS.
(BUKO-Pharmakampagne, 5 S. 12.500 Zeichen)

1. **3.) Globalisation and Health – Social Security Systems**

Generell: Neoliberale Liquidation von Sozialstaatlichkeit & sozialen Rechten; spezifisch im Gesundheitswesen: vollständige Abwesenheit in der Informalität, Deregulierung dort, wo wenigstens im Ansatz realisiert: Das "Modell Chile" und die Umkehr der "nachholenden Entwicklung", die angekündigte Gesundheitsreform in der BRD. Die Ungleichzeitigkeiten: Versuche der Re-Regulierung. Die Krise des neoliberalen Modells. Von der Defensive in die Offensive: von der Verteidigung des Solidarprinzips zu seiner Globalisierung.
(Jens Holst, 8 S., 20.000 Zeichen)

2.) History of Health Policy and social Security

1. **1.) Globalisation and Health – Historical Perspective**
   Health Concepts in times of Colonialism, Postcolonialism, Neoliberalism

Epoche des Kolonialismus / Kolonialmedizin: Cordon Sanitaire, Seuchenkontrolle zur „Sanierung" des „Grab des Weißen Mannes" und zur Produktivitätssteigerung der kolonial Ausgebeuteten, Hygiene als „Kulturimport" in den „schwarzen Kontinent" und Erziehungskonzept für die „niederen Rassen"
Epoche der Dekolonisierung & der Gründung der Entwicklungsstaaten: Primary Health Care als Anspruch auf „Gesundheit für alle" oder als symbolische Gesundheitserziehung für Arme, etc.
Ende der nachholenden Entwicklung, ausschließende Globalisierung, Staatszerfall, Bürgerkriegsökonomie, soziale Gewalt, "Freisetzung" in die Gewalt: Vertreibung, Massenmigration, barbarisches Stadium des Kapitalismus: was heißt da denn "Gesundheit": Interventionistische Strategien gegen die „Big Killers", Ökonomisierung der Gesundheitsplanung mit cost-effectivness-Analysen, Health Care Packages - Einsatz der NGO als neue Charity-Strategie , Privatisierung: Public-Privat-Partnerships, Public-Private-Mix.
(Maria Zuñega, 10 S. 25.000 Zeichen)

2. 2.) History of social security in Germany

Worker's Movement, class-Compromise – Integration – Bismarck's Reforms - Die Garantie des Solidarprinzips - Neoliberale Deregulierung/Privatisierung - Entsolidarisierung – Widerstand.
(Dietrich Milles, 5 S., 12.500 Zeichen)

3.) Primary Health Care – concepts – experiences - movements "

3. 1.) Concept of Primary Health Care

Die Erklärung von Alma Ata - Alma Ata und die Folgen - Das Scheitern - was bleibt, wofür kämpfen, wie weiter?
(Andreas' Kapitel im 30-Jahre-Text, 8 S., 20.000 Zeichen)

3. 2.) Economy of Primary Health Care:
Soziale Sicherung von unten – Experimente, Modelle, Grenzen
(Jens Holst u.a., 8 S., 20.000 Zeichen)

3. 3.) Country-example: Nicaragua
medico-Projektarbeit im Kontext des Sandinismus – Post-Sandinismus: Rio San Juan - CEPS - Waslala – El Tanque
(Walter/Nathan, 5 S. 12.500 Zeichen)

3. 4.) Country-Example: India
Gesundheitsbewegung von Bophal bis zur Community Health Cell
(Theima und Ravi Narayan, 5 S., 12.500 Zeichen)

3. 5.) Country-Example: Germany
Gesundheitsbewegung in den 70/80er Jahren: Sozialistisches Patientenkollektiv, Gesundheitszirkel in den Betrieben, Gesundheitsläden, Gesundheitstage, die missglückte Wiedergeburt auf dem Gesundheitstag 2000
(Christine v. Rauch, 5 S. 12.500 Zeichen)

4.) Health Projects in Globalised Times

4.1. Guatemala/Mexiko: Gesundheitspromotoren fordern ihre Anerkennung vom Staat aber verlassen sich nicht auf ihn
(Dieter, 3 S., 7500 Zeichen)

4..2. El Salvador: PODES - Kriegsversehrte Kombatanten nehmen die Reintegration ernst und die Prothesen selbst in die Hand
(Walter, 3 S., 7500 Zeichen)

4. .3. Südafrika: PSV in KwaZuluNatal, Psychosoziale Arbeit in gewaltzerrütteten communities fragt auch nach den gesellschaftlichen Bedingungen von Gewalt und Armut.
(Usche, 3 S., 7500 Zeichen)

4. 4. Palästina/Israel: Kooperation UPMRC – PHR, Basisgesundheitsarbeit ist nicht neutral angesichts Krieg, Besatzung und gegenseitigem Haß.
(Andreas fragt an, 3 S., 7500 Zeichen)

4. 5. Südafrika: De Kampf um AIDS-Behandlung für alle Betroffenen oder privatisierte Wasserversorgung, die Cholera-Epidemie und der Kampf um 50 Liter Wasser für alle BürgerInnen Südafrikas
(David Sanders, 3 S. 7500 Zeichen)

5. Politics of PHC internationally/nationally: Health is moving

Globalization is bad for Health
or
Is Globalization bad for health?
or
The present form of Globalization is bad for your health.

The Alma Ata conference of 1978 set a goal of "health for all using the primary health care approach as a strategy." In the intervening years, that goal has been replaced by the reality of "health for all who can pay for it." Health is no longer recognized as a human right, but as just another commodity to be distributed according to the ability to pay. This is seen most sharply in the privatization of health services in many countries around the globe, and the assertion of intellectual and patent rights by pharmaceutical companies which seal the death sentences of millions of sick people who can't afford life-giving drugs.

As the "right" of corporations to profit has displaced previous common rights, the determinants of health are also rapidly falling to the onslaught of profit. Water and the right to clean water is obviously a necessity of life: but it is no longer a right. The commodification of water is creating hardship and cholera (and other illnesses) around the globe.

As countries are forced to open their markets by World Trade Organization agreements, subsistence and small farmers are being increasingly driven off the land. Food security is disappearing from the agendas of world leaders as no longer relevant while malnutrition and starvation increases for people on every continent.

Toxic poisoning of water, land and air makes people sick, but attempts to hold corporations responsible are considered restraints on trade and made illegal. The list can go on and on, but it all illustrates one thing: what we know as globalization is making us sick. And its affecting all countries – rich or poor, developed or developing.

Asserting our right to control our own health and the health of our communities through people centered care and preventive measures is our alternative to globalized illness. This is a common sense approach, which was the core of the Alma Ata Declaration; unfortunately, it now runs counter to the rules of the World Trade Organization and the corporate desire for the primacy of profits even in Health. We continue to believe that people should come before profit, and we must reassert the need for primary health care before the challenges to health become unmeetable. That's why we say, "Health for all, NOW!"

The Peoples Health Movement (PHM)

The Peoples Health Movement was formed in Savar, Bangladesh in December 2000. Uniting 1500 representatives from 92 countries, its founding statement underlines the need to reclaim "Health for All" in the face of the inability of individual governments to achieve it, the abandonment of it in principle by the World Health Organization, and the harmful actions of corporate-led globalization. The Peoples Charter for Health which evolved at the end of the Assembly is now a document for dialogue and advocacy.

Since that meeting, various countries and regions have set up their PHM circles to work on specific campaigns. The PHM is most active in India South Asia and Central and South America, with smaller working groups in North America, Europe, Africa and xxxxx. The Secretariat for the PHM is currently located in Bangalore, India led by Dr. Ravi Narayan, a community health physician, who has worked with civil society campaigns and movements for over two decades.

PHM-North America

In the United States, Doctors for Global Health (Atlanta, GA) and the Hesperian Foundation (Berkeley, CA) have taken the lead in beginning to organize a presence in North America. Given our strategic location in the United States, various circles of the PHM have asked us to focus our initial organizing on providing networking and promotional support for the various country and regional campaigns of the PHM, and working to raise consciousness in the United States about the challenges to health around the world posed by globalization.

We hope to coordinate with already existing organizations to counter the effects of privatization and the retreat from health here in the United States. We have begun to reach out to Physicians for a National Health Plan and other single-payer, immigrant and human rights organizations in the U.S.

Spring 2003 activities

In March 2003, we will be hosting a visit of some PHM leaders from South Asia. Dr.Zafarullah Chowdhury was the founder director of Peoples Health Center (Gonoshasthya Kendra) in Bangladesh, which hosted the first Global Peoples Health Assembly. Dr.Ravi narayan is the coordinator of the Peoples Health Movement Secretariat, currently located at Bangalore and Dr.Thelma Narayan is a well known Public Health Policy activist and researcher, who was deeply involved with the Peoples Health Movement mobilization in India.They will be attending meetings and events in California, Washington, and Oregon, and in New York, Boston, and Washington, D.C.

Dr. Chowdhury of Gonosthaya Kendra (Bangladesh) will speak about the importance of primary health care, the training of women health workers, and the production of essential medicines to break the stranglehold of the big pharmaceutical companies. Dr. Ravi Narayan will speak about the importance of including health issues in the current activities against globalization, the paradigm shift in health action which allows people to organize around issues of primary health care; and campaign to increase access to basic determinants of health - all of which or constituents of peoples health movement initiative in different parts of the world.

Dr. Thelma will speak on effects of globalization on Women's health; on adverse effects of inappropriate policies on health of the poor; and how a participatory people oriented policy process can better address health needs focussing on TB control as an example.

Contact

For more information about the PHM/North America, contact: Sarah Shannon, Hesperian Foundation. Mollie Williams, Doctors for Global Health. Visit the PHM website: www.phmovement.org.

Zafrullah Chowdhury

Zafrullah Chowdhury has spent decades-bringing health care to the undeserved rural population in Bangladesh. Chowdhury founded the non-governmental organization Gonoshasthaya Kendra, or the People's Health Center, in 1972 to provide primary health care services for rural communities. The organization has trained women with a low level of technological expertise to deliver primary healthcare, providing immediate medical relief to poor people using principles of community medicine and low-cost effective healthcare. He also pioneered the Gonoshasthya Pharmaceuticals to produce essential drugs for primary health care in Bangladesh. In 2002 Dr. Chowdhury was honored by the University of California, at Berkeley, with the Public Health Heroes award, which recognizes individuals and organizations for their outstanding achievements in the advancement of public health and health care.

Ravi Narayan

Dr. Narayan is Community health physician, who was professor of community health at St.John's, one of India's most community oriented medical colleges at Bangalore, India. He then moved beyond academic teaching and research to work at grassroots inspiring of community health workers and non-medical professionals to be involved in community health action. Particularly impressive is Ravi's vision and experience working both at the grassroots to train non-medical professionals to promote the paradigm shift for community health, and at "scaling up" this through coalition building with networks and campaign groups within India. Dr. Narayan is Joint Convenor of the leading circle of the People's Health Movement in India and coordinator of the international People's Health Movement lobby efforts with the WHO. The PHM efforts in India have focused on grassroots organizing to lobby for changes in health policy priorities.

Thelma Narayan

Dr.Thelma Narayan's an epidemiologist and public health policy researcher has focused on Public Health Policy Action; in a wide range of areas including Tuberculosis control and HIV-AIDS; Women's Health Empowerment; Tobacco Control-Demand and Supply issues; and Globalization and Health particularly Women's Health. She has also been a Health Policy consultant to Karnataka and Orissa governments, evolving peoples oriented State Health policies; and a member of the Caritas International Aids Task Force and Poverty and AIDS Circle of Peoples Health Movement. She is also the coordinator of the Community Health Cell (CHC), the functional unit of the Society for Community Health Awareness, Research and Action (SOCHARA), which was one of the active members of the National Coordination Committee of Peoples Health Movement in India.

GLOBALISATION AND HEALTH

* Economic Globalisation, in the process; trade liberalisation, Financial Speculation, Foreign Direct Investment and neo-liberalization

* Globalisation excitement in some and fear in others

  Positive : Globalisation will increase the inter connectedness of countries, people, Ideas, Products And Services, in turn improve the chances for solving the current pressing problems of humanity

  Negative : Widening gaps between rich and power any marginalise groups and problems.

Some important threats of Globalisation

* **Globalisation could lead to a faster spread of infectious diseases through, for example, trade in unsafe food.**

* **Media advertisements and inappropriate marketing of pharmaceuticals had lead to the widespread distribution and use, increasing the resistance to a range of diseases.**

* **Moving people on normal and business contributed some extent.**

* **Spread of non-communicable diseases**
  Increasing the use of Tobacco due to massive multimedia marketing campaigns portraying it as a desirable life style.

* Violence - Trade in weapons

Globalisation of Health' has been halted because

* WHO has lost its leadership in health policies around the world.
* Power shifted to WB, IMF and becoming the real health leaders for developing countries.

* Public Health - Services and health care for all are now perceived as an obstacle, threatening public finance and wealth of nation
* Reduction in health expenditure has become one of the top priorities for all governments.
* The model of primary health care as fundamental for the prevention and treatment of diseases has been almost abanded, trend is dismantling the machinery of public health.
* Priority is given to costly technologies
* Community service replaced by private insurance
* TNC TNCs control 10 percent of the world trade and 80 percent of all land growing export crops. Yet TNCs employ only 3 percent of world paid labour. Their huge profit go mainly to the limited owners.
* Toxic Waste There are attenmts to dump toxic waste and harmful industries in developing countries.

Structural adjustment - programme.

* Reduction in public expenditure on social work, public health, education and other basic necessities.
* Public sector to private sector
* Export cash crops etc.
* Devaluation of Indian money
* Liberlisation etc.
* After SAP - Marginalised have increased
* over a billion deprived of basic consumption needs
* 3/5th deprived of basic sanitation
* 1/3rd have no access to clean water.
* 1/4th with no adequate housing
* 1/5th do not attend school grade-5
* 1/5th do not have enough dietary energy or protein.
* Two billion are anemic worldwide.

Pattern Laws :

Indian Pattern Act 1970

- Process pattern
- Product pattern
- GATT & WITO

* Globalisation creates new wants (not necessarily needs) by manipulative advertisements of new medical technologies.
* Cash crops instead of food crops.

What to do

* Improve coping strategies (short term)
* Build networks of Peoples Movements that can have joint action against globalisation (long term)
    - Improve good governance
    - Involvement of ordinary people in planning or merger
    - Evolve power to local levels - panchayatraj
    - Decentralization
* Redefine public health to community health (local community at centre of scheme)
* Workable infrastructure of health
* Develop larger and networks
* Build on Peoples Movements
* Protect / develop traditional knowledge and skills

Role of NGO's in People's Health

* Advocacy role
* Training role
* Networking role.

TRIPS AND PUBLIC HEALTH

1. ICMR organized a 2-day Consultation on the subject. Amit Sengupta, Dinesh Abrol and I participated. The Consultation was called by Dr. Suryanarayan with Mr. S.P. Shukla, former Indian negotiator to GATT and Convenor of Indian People's Campaign Against WTO and Globalization. Mr. B.K. Keayla, Convenor, National Working Group on Patent Laws.

   I dealt with threat of GATS besides TRIPS and Health challenges.

2. UNICEF organized a small Consultation of UNICEF, Chief, Carol Bellamy with a small group of NGOs, child health experts, planning commission health advisors etc. Presentations were made on child health situation, polio status and the meeting was chaired by Mr. Hota, Secretary, Family Welfare.

   I mentioned the past relationship of VHAI with UNICEF on

   - Baby food issue
   - Rational diarrohea care, withdrawal of irrational and hazardous anti-diarroheals.
   - Iodine deficiency in endemic areas of tribals in Madhya Pradesh in early 80s in Raigarh.
   - Sex determination and female foeticide.

   Concerns were expressed by me regarding:

   1. Withdrawal of UNICEF from drinking water. (Mark II handpumps were popularized by UNICEF.

   2. The problem of availability of ORS packets was presented by Dr. Paul/Dr. Bhan. I raised the concern that precisely because of the non-availability of ORS discouraging home made ORS, calling it unscientific was not in the interest of diarroheal victims. As dependence on cheap UNICEF/WHO ORS packets which were not easily available and commercial ORS packets costing upto Rs. 10/12 per packet, diarroheal deaths continue to exist and diarrhea is still a major killer of children.

   3. Vit. A in house to house campaign mode to children with no Vit. A deficiency as was done in Assam where some deaths following immunization had taken place highlighted the need for comprehensive approach to nutrition problem where vit. A, Calcium, Iron, rich foods needed to be encouraged.

From Dr Mira Shiva
15/12/03.

4. TRIPS, public health and availability of essential life saving drugs for children, role of UNICEF in International Trade Regimes.

3 **5th Ministerial Meeting, Cancun, Mexico**

Recognizing that attempts to dilute Doha Declaration was being systematically diluted and decisions on para 6 of TRIPS ie., availability of drugs for LDCs without manufacturing capability with parallel imports being allowed by U.S. with great reluctance. This was done with several conditionalities.

- Both countries should have compulsory license in its National Act.
- Size, shape, form and colour of these medicines to be exported by manufacturers of generic equivalent drugs
- The TRIPS Council in Geneva was to be informed about every compulsory license given.
- In the name of transparency it was to be put on the web page and this information was also sent.
- Proof of lack of manufacturing capability of the importing country had to be given.

The announcement of this from Geneva was mistakenly seen by many as an achievement for both poor importing countries and the middle income drug exporting companies of generic equivalents of patented drugs eg. India, Brazil etc.

The complications and conditionalities unfortunately make the use of this flexibility of parallel import difficult for both countries full of hurdles and insecurity. This was hailed in our newspapers as a great breakthrough of TRIPS. Para 6 negotiations few days prior to Cancun with US allegedly 'having given in the interest of public health of poor nations' was projected.

What was conveniently left out from the Cancun draft was any mention of the TRIPS review which was to take place 5 years after launching of WTO in 1995.

What was also conveniently dropped in Cancun of what was present in the Doha Declaration in Article 27.3(b) of TRIPS, the issue of indigenous

knowledge and biopiracy. Since any discussion of this would clearly show the exploitation of indigenous knowledge taking placewithout any compensation nor acknowledgement of the original source. Patenting of life forms is in violation of CBD- Convention on Biodiversity (not signed by U.S.)

TRIPS and Public Health agenda item passed through in Cancun without much challenge. It was the Agreement on Agriculture (AoA) which divided the countries in those providing deep subsidies to their farmers, including hiring export subsidies, making production of farmers from majority of the world relatively unremunerative. Many farmers caught in the seductive dream sell of increased `market access' in developed countries of their export oriented agriculture - had become paupers as neither they could compete with subsidized agricultural products of US and EU market nor their products find domestic procurement and sales as prices were made very unremunerative. Forced imports of cheap food further displaced farmers as their own governments lifted the little local subsidies given to them on one hand and lifting tariff barriers where imports were concerned. Changes in the non-tariff barriers constituting of regulations etc were also made.

Massive protests by peasants and farmers and their supporters, anti-globalization groups were held. Mr. Lee a 37 year old Korean farmer, a father of 3 girl children. He immolated himself in protest on realizing the hopelessness with US and EU refusing to comply on decreasing of heavy subsidies given to their own farmers. The Mexican government expressed its condolences and Cancun Municipality sent flowers as Korean farmers sat on the site in silent protest. Protest banners were put up on high rise buildings, creative posters, pins, T-Shirts communicated the mood of the civil society. WTO was unjust and it killed the poor.

Numerous workshops, seminars, press conferences, material showed that people had a better understanding of what was going on, as evidence of the distress created for the poor by the negative impact of WTO was documented by different groups - Activists, researchers, scholars, sociologists and development workers.

A lot of the analysis was done by scientists, development workers, from the viewpoint of the `South' by the people of the South.

International Forum on Globalization (IFG), RFSTE, TWN, RIS, Focus on Global South being some of them many NGOs from the North - Actionaid, MSF, Oxfam Heinrich Boell Foundation communicated the same concerns in their various workshops.

The fact that the Brazilian delegation and the Indian delegation led by Mr. Arun Jaitley were speaking in the same tone along with G21 ie. groups of 21 countries eg. Brazil, China, Venezuela was unprecedented. The desire of these delegations to meet the NGOs and communicate to them that a joint resistance front constituting of Governments of developing countries and NGOs of North and Soutyh to resist unjust inernational trade regimes was needed, was unprecedented. Earlier many developing countries tended to defend the 'WTO' obligations so as not be left behind and as they suffered from `There is No Alternative' - TINA Syndrome.

Many actually believed that such a market led globalization process would benefit the world, others said so in return for the heavy consultanicies and funds received and belonged to the HMV category to replacing HIS Masters Voice. Many of the individuals and organizations were quite unprepared for across the Board resistance from developing countries, the civil society and thousands of marginalized farmers, peasants and women's groups.

This resistance to the aggressive unilaterally benefiting agenda being forced on the rest of the world was seen as unjust and also as community and society destroying people and health destroying exercise being pushed by Corporate agenda - The main players of course were US and EU.

Security arrangements

Barricades and Barricades with the entire place dotted with well armed police was a Cancun site. Many participants had to walk for miles as their buses would be stopped and not be allowed to proceed as workshops, briefings and meetings were taking place in different places sometimes in totally opposite directions and a lot of commuting was required.

Transport

Due to barricades transport was difficult. Most of us took buses. Those with money used the costly taxis.

Communication

Communication was not easy because of the Spanish language, non-functioning of all phones of most people including those with roaming and the triband facilities. As these were not compatible, new cell phones had to be bought by those who could afford them. Absence of phone facilities did interfere with effective communication. On the day of our drug protest the local bus for security reasons dropped me almost 1 1/2 km way from

the Convention Centre in the pouring rain and I reached the Convention Centre dripping wet inspite of an umbrella which I took from India.

I managed to join the protest.

The police however were not hostile nor baton and trigger happy.

Many felt that the NAFTA North America Free Trade Agreement had already been implemented in Mexico and had created enough distress for the people and they realized what WTO could further mean. With FTAA - Free Trade Agreement of the Americas which is to be extended to 36 American countries in a shape worse than WTO additional concern was felt by the people in the region. The protests by the `Campesinas' peasants from Central American region was massive. They knew where the shoe punches and they knew what walking barefeet on nails is like.

Drug Action

The drug groups met and gave a joint statement on behalf of MSF, HAI, GAP act up Oxfam, PHM, IPHC, Diverse Women for Diversity, Third World Network, Consumer International.

In the Convention Centre where only the registered official delegations were permitted to go -- on the opening day -- anti-WTO activists protested by putting up placards.

On 11th the drug activists entered the Convention Centre taped themselves with a red tape, on black clothes - symbolizing empty gift tied with red tape high lighting the hollowness of the text related to parallel imports with large number of conditionalities. Slogan shouted was `medication for all nations'. It is precisely this group of drug activists which had forced US to back off from the dispute case if filed in WTO, it was precisely this group which had showed the 39 pharmaceutical companies withdrawing their case against South Africa for wanting to produce anti-retroviral drugs under compulsory licensing. Silent protests were held by placing flowers on the picture of Mr. Lee in the Convention Centre to highlight the fact the `WTO kills farmers".

Sessions attended by me:

Women's Forum

I was asked to speak on TRIPS and public health at the Women's Forum in Cancun. Besides dealing with the issue, I mentioned about the long fight of drug activists, role of People's Health Charter and PHM. Women

and Trade Network addressed WTO issues, specially water, food and agriculture.

International Forum on Globalization

I was asked by the organizers to be a panel member on TRIPS and public health (the request was made the night before the meeting).

I dealt with TRIPS what it meant in the area of pharmaceuticals, TSM etc. Cost and access to medicines etc., People's Health Assembly.

There seemed to be fear of certain facts, certain information from reaching the people. The reason that Governments are being pushed to take EARLY decisions without issues affecting millions IRREVERSIBLY giving due time for discussions and debates.

Since IFG has played a major role globally in addressing these issues, an attempt to sabotage their teach-in was made. Repeated Radio announcements were made that the meeting was cancelled and buses were barricaded and did not let the participants wanting to attend the teach-in including the speakers get down and the few vehicles that reached the gate, were not allowed to stop by a strong contingent of police force.

In the NGO Forum, several things were going on - on food security, GATS, Singapore issues, new issues, WTO briefings were done in Hotel Fiesta near the Convention Centres. It was not possible to travel long distances in buses which went in real round about way and still be in time.

Weather was very hot, humid with intermittent rain. This added to the exhaustion of those who had to walk long distance or who went on protest marches with the peasant farmers. A march in solidarity for the African people was also held.

Most of the participants were committed and serious people. There always is a small minority of youth who feel angry and frustrated at the greed, selfishness, tactics and blatant double standards eg the blatant double standards in the behaviour of few countries namely US, EU. In one of the sessions on food security organized by WEMOS, ICCO etc where the Dutch Agriculture Minister was invited. Her blatant and aggressive support of WTO and its neoliberal policies left the participants shocked with disbelief.

The Cancun Draft

No one knows how the drafts are prepared, what is the process, how the concerns of poorer countries are addressed. The guess is that it is formulated by the supporters of the corporate interest, The large number of lawyers and drafting experts in the U.S. delegation are obviously involved in drafting specially at the critical drafting stage. Views of countries are taken in an adhoc manner as group.

The Chairman's draft is supposed to be discussed rather than a draft that reflects the views of the majority. It was the total overlooking and non-inclusion expressed concerns of G21 that made the G21 more agitated.

The shocking thing is that no-records are kept for ever being able to check out whether what is communicated later as a consensus draft -- is recently consensus.

The demand for EXPLICIT consensus by Dr. Musorali Maran in Doha Nov 2001 had been taken up by the Indian delegation as well as NGOs of North and South.

In fact bands of explicit concerns were made by Northern NGOs which included the word in Hindi as sampoorna, sahmati.

The T-shirts with these words "Explicit Consensus" were in great demand and were even by official delegates, including Brazil and India.

Monsanto

Monsanto one day attempted to donate genetically modified food for the community members of one of the rural villages. The anti-GM groups followed them, demonstrated and told the villagers about the rejection of GM food by many enlightened consumers as well as governments.

With foreign media brought in by Monsanto to cover the Act of Charity boom ranged on them, as the media landed up highlighting the protest against Genetically Modified Foods by protesters. The protestors also explained to the villagers why they were protesting and how GM foods resulted in corporate control on agriculture, further marginalising the poor peasants, besides safety concerns.

Fair Trade

Nobel Prize winner Rigoberto Menchu and Dr. Vandana Shiva inaugurated the Fair Trade where organic farmers from different parts and coffee growers, people from Chiapas had set up their little stalls.

The demand for Fair Trade over Free Trade was heard over and over again. Protectionism by rich countries while demanding market access in developing countries in the name of free market needed to be resisted. The linking of the consumers and farmers without the middlemen was seen as very important. (The reminder that farmers produce food and corporations merely trade in food and not produce it, it must be remembered farmers made destitutes and with profits of Corporations increasing it was becoming evident that the rules of the WTO were in the interest of the Agro industry and the other countries into export oriented crops, food production is to be affected negatively.) It was also clear that the national interest could not be safeguarded with National Treatment which meant that TNCs have to be treated like domestic companies even if it was based on any understanding. Most favoured nation actually meant that no country could be given a better treatment than any other. Government purchase ie all purchase had to be transparent and open for TNCs too. The loss of national sovereignty is expected and built into these regimes.

Changes of once our national laws and policies to ensure profitability of foreign investors and safeguarding them against any losses, with national governments making up for the financial losses it made.

I did not know Cancun was a tourist spot created 30 years for rich Americans and other tourists, by creating artificial lagoons that it was so hot in Cancun in spite of the closeness of the sea. Maya civilization temples were 2 hours away by air.

Since had to return to work, due to seriousness of the situation and issues involved due to resource and time constraints, I could not do anything which in other circumstances one would have done. I did not even get totouch the sea nor see the **Maya** civilisation temples two hours by air.

Thanks to the Haldiram peanuts and chana I took as a vegetarian and as financially constrained participant that I managed in a non-posh hotel AMOSOL a very small room on shared basis which was changed at the last minute.

The collapse of Cancun, the formation of G-21, the exposure of the double standards and increasing protests by civil society and objections raised by developing country governments clearly shows that the unjust regime can't be forced down the hearts of poor nations. For a large number of fence sitters too the message is clear that protests against WTO is not isolated noise made `rabid radicals', doomsdayers' , it is by millions of existing and potential victims of the unjust trade regimes -- which will become global poverty inevitable increasing socio-economic political and gender inequity.

Use of military power for control of resources was obvious. The effort to divide G21 would be expected and also increasing use of bilateral and regional trade agreements which would be harsher than WTO. It is also clear that US is failing to get what it wants through WTO regime would do so by putting bilateral pressure or through the World Bank and IMF linking loans to some conditionalities. Opening up of the water sector for privatisation by E.U. is an example.

Learnings

Plan early confirmation of the programme

Check the weather and carry appropriate clothes.

Lot of glare - acquire numbered sunglasses

Lean to use internet to send your messages

Lean about different ways of communicating by phone

Ensure names, addresses, phone contacts with people or has to work with.

Carry a camera that works with extra batteries and rolls.

Material picked up

Another Development is Possible - IFG

Social Watch World Trade and Development Report

Word Trade Report Globalization

MFC

TWN Briefings

IFG Kit

Public Citizen Kit

Maude Barlow Kit

THE GATS THREAT TO PUBLIC HEALTH

A JOINT SUBMISSION TO THE WORLD HEALTH ASSEMBLY

MAY 2003

Within just 10 years of its adoption, the General Agreement on Trade in Services (GATS) has become one of the most controversial elements of the international trading system. More and more countries are becoming aware of the threat posed by the scope of the GATS agreement, and there is a growing call for governments to defend essential services from the GATS liberalisation agenda.

This briefing examines the threat which GATS poses to health. It looks first at the challenge to health services themselves, including the potential for increased inequity, fragmentation of health systems and further marginalisation of the public sector as a result of the increased marketisation of health care.

The briefing also examines the health risks which come with liberalisation of other service sectors such as water and insurance, and reveals the challenge to national health regulations from current negotiations at the World Trade Organisation (WTO).

In conclusion, the briefing recommends that no country should commit its health services to GATS. In addition, each country should actively involve its health ministry and civil society in comprehensive 'health checks' of any GATS commitments proposed in other sectors before deciding on them.

How does GATS work?

GATS commits WTO members to successive rounds of negotiations "with a view to achieving a progressively higher level of liberalisation" in their service sectors. To achieve this, WTO members make liberalisation requests of other member countries in secret, bilateral meetings in Geneva so as to open up to competition those sectors which are of most interest to their own service providers.

The current round of negotiations is now entering its most intense phase, when countries battle over which service sectors they will give up to liberalisation and which they will protect from GATS. Although developing countries officially have the right to choose whether to commit a sector to GATS, in practice they come under intense pressure in these negotiations to meet the demands of more powerful WTO members – pressure which the smaller and poorer countries are often powerless to resist.

In this way, GATS is primarily a mechanism for the service corporations of developed countries to expand their reach into new markets around the world. This is widely acknowledged by official negotiators: the European Commission has confirmed 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."

GATS and health services

When GATS was adopted in 1994, few countries were aware of the challenges it would bring. Very few government departments other than trade and finance ministries were involved in the negotiations, and several countries committed all or part of their health services to GATS liberalisation without the knowledge of their health ministries.

According to the WTO Secretariat, 42 countries have already committed their hospital services to GATS. In addition, 15 have made commitments under the category of 'other human health services', which include laboratory, epidemiological and residential health services, as well as podiatry and chiropody services supplied in clinics and elsewhere.

Health services are also included under the GATS heading of 'professional services', which covers medical and dental services as well as the category of 'services provided by midwives, nurses, physiotherapists and paramedical personnel'. Already 52

countries have made liberalisation commitments in the former category, and 28 in the latter.

GATS also covers insurance services, including health insurance, and 78 countries have already committed those services to liberalisation under GATS. This has caused particular concern in those countries which base their health systems on social insurance programmes, since few health ministries were informed that their trade negotiators had committed their health insurance sectors to GATS.

The above figures may suggest that many countries have largely committed their health sectors to GATS already. Yet out of all sectors covered by GATS, health and education are the two in which fewest commitments have been made. As a result, the WTO sees the current GATS negotiations as an opportunity to achieve further liberalisation in those sectors.

In fact, many countries have deliberately withheld their health services from GATS liberalisation in recognition of the great uncertainty surrounding what a GATS commitment might mean for health care. It is only now, in the current round of GATS negotiations, that health services may again come under threat of liberalisation.

The GATS threat to health services

Providing basic services for all requires strong government regulation and a proper understanding of where liberalisation may be beneficial, and where not. Yet the 'request-offer' process of GATS negotiations is designed to open up more and more service sectors to competition through a series of trade-offs at the WTO, rather than concentrating on which type of system is most appropriate for which particular service.

This is of special concern in the case of health services, where the market-based model of competition threatens the integrity of health systems themselves. Health is a human right and a public good whose positive externalities cannot be captured through market mechanisms. As such it is not suitable to commit health services to binding liberalisation under GATS.

Nowhere is this more clearly seen than in the threat of competition from foreign hospitals. Even in countries where the public sector already faces competition from domestic private hospitals, the additional challenge of hospital services provided by foreign private sector health providers exerts extra pressure on public health systems which are already under severe strain.

For those patients who can afford them, high-tech foreign hospitals may offer an unparalleled level of health service. They also offer medical personnel an opportunity to practise their profession in the most modern and fulfilling environment, and often at far higher rates of pay.

Yet by attracting the most experienced staff and the most affluent patients away from the public sector, expansion of the private sector undermines the integrity of the health system as a whole. As WHO affirmed in its *World Health Report 2000*, leaving the public sector to provide services only to the poorest and most needy patients undermines the possibility of cross-subsidisation and risk pooling on which sustainable health systems are based.

For the vast majority who are unable to afford the high costs of foreign private sector health care, the promise of 'increased choice' as a result of

THE FOUR GATS MODES OF SERVICE DELIVERY

GATS distinguishes four different 'modes' of services, all of which are relevant to health services:

1. **cross-border supply:** – where the service is provided remotely from one country to another, such as telemedicine via Internet or satellite, or international health insurance policies
2. **consumption abroad:** – where individuals use a service in another country, such as patients travelling to take advantage of foreign health care facilities, or medical students training abroad
3. **commercial presence:** – where a foreign company sets up operations within another country in order to deliver the service, such as hospitals, health clinics, insurance offices or water distribution operations
4. **presence of natural persons:** – where individuals such as nurses, doctors or midwives travel to another country to supply a service there on a temporary basis

liberalisation is therefore a hollow one. Rural communities in particular risk seeing their access to health care undermined by the expansion of the private sector, as foreign hospitals draw away their remaining doctors, nurses and midwives to serve the urban elite.

Health risks of other GATS liberalisation

The financing of health systems faces a similar challenge from GATS liberalisation. National health insurance systems can be seriously undermined by such liberalisation, as competition from foreign providers threatens the sustainability of programmes designed to spread costs across society and provide affordable health care for all.

Yet it is not only in respect of health systems that GATS poses a threat to health. GATS covers a wide range of other service sectors with direct links to health outcomes, and liberalisation poses a threat in many of these sectors too. Public statements by the European Commission that the EU is making no GATS requests in health services fail to acknowledge the potential health impact of its extensive requests in other sectors.

For example, the EU is attempting to use the current round of GATS negotiations to open up the water sectors of 72 other WTO member states – including both developing and least developed countries. There is evidence from developing countries across Latin America, Africa and Asia that liberalisation of water systems typically raises water tariffs beyond the reach of many poor households and can cause severe health problems, especially among children.

As a result of such experiences, several developing countries which experimented with liberalisation in their water services have taken the service back into public hands. Yet once a sector is committed under GATS, punitive rules on the modification of national commitments make it effectively impossible for a country to reverse liberalisation in this way.

This is because WTO agreements are designed to bind liberalisation commitments for the future so as to give foreign investors increased security – even if this means exposing vulnerable communities and their children to increased levels of risk. Many commentators see this 'lock-in' mechanism as the most dangerous aspect of GATS, since it closes down the possibility of reversing excessive or damaging liberalisation in the future.

'NECESSARY' REGULATION?

The USA's 1990 challenge to Thailand's longstanding ban on tobacco imports shows how the WTO could interpret whether a domestic regulation is 'necessary' or not. WHO supported the Thai government in its defence that opening its market to imported cigarettes (and the advertising which goes with them) would inevitably lead to an increase in smoking, especially among women and young people, and that the import ban was therefore necessary to protect public health. Yet the pre-WTO dispute panel ruled that the ban was a restriction on trade which was not 'necessary', and called on the Thai government to remove it. The WTO has since cited the decision as precedent for its own rulings in similar cases.

GATS and public health regulation

As shown above, GATS has gone further than any other multilateral trade agreement to bring the WTO's liberalisation agenda into the heart of national policy. This is particularly true of the GATS rules on domestic regulation, which are still being developed at the WTO.

GATS states that domestic regulations in WTO member countries must not pose "unnecessary barriers to trade". It also mandates the WTO's Council for Trade in Services to develop new GATS rules to ensure that technical standards or licensing requirements in WTO member countries are "not more burdensome than necessary to ensure the quality of the service".

Yet there is widespread concern that these GATS rules will threaten key public health regulations in WTO member countries. The GATS requirement that regulations must be 'necessary' in WTO terms could expose any domestic health policy to challenge at the WTO.

India's progressive new regulations on the marketing of baby foods are just one example of the type of 'restrictions' which could be under threat. The new regulations, approved by India's parliament in May 2003 in order to support breastfeeding, prohibit the promotion of breastmilk substitutes, feeding bottles and all foods for babies under the age of two years.

Yet such regulations could be interpreted as 'unnecessary' if the WTO decided that there were other ways of achieving the same public health objectives – even if there were specialist evidence to the contrary (see box on page 3).

This has raised fears that other key public health controls, such as restrictions on the marketing of alcohol and tobacco or regulations governing private hospitals, could also be threatened by GATS rules on domestic regulation, once they have been adopted at the WTO.

WHO officials have openly voiced their opinion that the WTO cannot be trusted to uphold legitimate public health provisions, and many other organisations have called for a halt to the domestic regulation negotiations at the WTO.

GATS and the migration of health personnel

In addition to the establishment of hospitals, clinics or insurance offices, trade in services also covers the movement of individual people to provide services abroad. In the case of health services, this 'trade' takes place when doctors, dentists, nurses, midwives or other health personnel move to other countries in order to practise there. In the GATS context, this is referred to as 'mode 4' (see box on page 2).

Many developing countries are using the GATS negotiations to argue for greater freedom for their nationals to work abroad, as they see this export of labour as an area of comparative advantage for their economies. Countries such as India, Mexico and the Philippines already receive over $5 billion per year each in workers' remittances, while in countries such as Tonga, Lesotho and Jordan, workers' remittances represent over 20% of national GDP.

Yet the export of labour is not necessarily appropriate in all sectors. In particular, the migration of health personnel to richer countries is already a significant and well attested problem facing health systems across the world.

Rather than promoting further migration in the pursuit of balance of payments gains, the vast majority of developing countries need to find ways of retaining key personnel in their own health systems, where their presence can make an immediate and lasting difference to the lives of many of the world's most vulnerable people.

Conclusion and recommendations

The current round of GATS negotiations have now entered their most intense phase, with countries being asked to liberalise sectors which they have previously kept closed to competition.

Yet the model of binding trade liberalisation at the WTO may not be appropriate for services which have a major impact on human health. For precisely this reason, several countries have stated that they are not going to offer up key service sectors to GATS.

ASEAN health officials meeting in Jakarta in 2002 concluded that developing countries should refrain from making health commitments under GATS, and called on all health ministries to ensure that their health sectors are not traded away at the WTO. The same policy has been adopted by the EU, USA and many other countries, all of which have stated they will not offer up their health services under GATS.

There have been similar calls for caution in other sectors, with South African officials calling for water to be taken out of GATS altogether. The same caution has been called for in other environmental services, as well as sectors such as tourism, energy, education and cultural services, all of which could be threatened by GATS liberalisation commitments.

In recognition of these dangers, it is recommended that all WTO member countries should:

1. **make no GATS commitments in the health sector or other health-related sectors;**
2. **conduct a comprehensive 'health check' on any other GATS commitments proposed by WTO trade negotiators, with the active involvement of health ministries and civil society;**
3. **call a halt to the current WTO negotiations on rules governing domestic regulation;**
4. **call for a change to GATS rules which restrict countries from retracting commitments already made under GATS.**

This statement is endorsed by the following organisations: Equinet, International People's Health Council, Medact, People's Health Movement, Save the Children UK, Wemos, World Development Movement.

EC-5.

Main Identity

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Sent: Tuesday, August 26, 2003 10:27 AM
Subject: Press Release: India's citizens protest against the Cancun Minist erial

Mass Demonstrations in Tamil Nadu and other parts of India against the Cancun ministerial.
Anti GATS action in all districts in Tamil Nadu on 26th August 2003

Press Release

There is a complex dilemma in governance that is ignored, and hence little understood, by policy makers. The Central government is committed to pursuing the process of India's integration with the world ostensibly because this global economic integration (or globalisation) will help boost India's economy and subsequently its living standards. Politicians and bureaucrats are increasingly viewing rapid liberalization of international trade, through various instruments in the World Trade Organization (WTO), as the undisputable vehicle to achieve development.

But the Indian Constitution also mandates the central government to adhere to concepts of a federal democracy while arriving at policies. Democratic politics are envisaged so that those that are directly affected make crucial public policy decisions by them- or their representatives. The 73rd and 74thamendments to the Indian constitution are a case in point to ensure that Panchayats and municipalities are devolved with adequate powers to take crucial developmental decisions that would reflect their local specificities.

Our position is that it is extremely difficult to pursue both these agendas simultaneously. In other words India's present agenda of global integration through centralized trade agreements is, and can be, achieved only at the cost of local democracy. This conflict between global integration and local democracy is perhaps best represented in the WTO's General Agreement on Trade in Services (GATS) which is the first multilateral trade agreement to create a legal framework for international trade in services.

TN
27/8

The major service sectors like Food, Water, Health and Education are the fundamental rights of the marginalized people in India. According to the 73 and 74th amendment the above service sectors were given to the local bodies to serve the local people. So the Government of India move to liberalise (which will lead to privatisation) these sectors under the GATS without any consultation with local bodies is violating the powers of the local bodies and the very spirit of the Indian Constitution

To Dr CHF: Should CHL send a letter re: GATS which will definitely have adverse consequence on the health sector + on access to care. Would you be able to draft a letter in this regard
27/8

Lib
GATS + Health file

23/10/03. It is now too late. Cancun meeting is over, without results.
= The point raised is interesting. There is need to consult experts in Constitutional law: Who has the power to enter into international negotiations? Should there be consultations before or ratification after? CM 23/x.

8/26/03

The 5th Ministerial meeting of the WTO is scheduled to be held at Cancun,

Mexico next month (10-14 September 2003). Various commitments will be made by India at this crucial ministerial and a sanction for deepening of commitments under the GATS is high on the agenda of developed countries like the European Union and United States of America.

In the past two months peoples organisations and local bodies federations all over Tamil Nadu have come out in protest against India's undemocratic engagement in the GATS negotiations. More than 200 groups, including presidents of rural local governments have written to the Prime Minister of India calling for a standstill in negotiations and assessment of GATS impacts before new sectors are opened up to foreign entry.

At these meetings it was decided that these groups would organise demonstrations on 26 August 03 in all district headquarters in Tamil Nadu as a sign of their serious disagreement with the GATS process.

Also on the same day as part of the peoples campaign against WTO we are mobilising signatures from citizens to send it to the Prime Minster by way of protest and requesting that we withdraw our country's commitments in the GATS which have been made surreptitiously by the Commerce ministry in 1994 without the consent of parliament, state legislatures and local governments

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Sent: Thursday, August 28, 2003 2:29 PM
Subject: 02 Press Release: India's citizens protest against the Cancun Ministerial

- PRESS RELEASE -
Stop the GATS Attack!

"Moratorium on all commitments under General Agreement on Trade in Services (GATS)" is the demand of more than 650 signatories including Panchayat Presidents and representatives, trade unions, farmers groups, mass organizations, NGOs and a large number of individuals in the country. They have voiced this demand by endorsing a letter prepared by EQUATIONS (Bangalore), MANTHAN (Badwani) and Focus on the Global South (Mumbai). This letter, which will be presented to the Prime Minister and Commerce ministry officials signals the beginning of a peoples campaign against the GATS. Among the trade unions and mass organizations that have made this demand are the All India Trade Union Congress (AITUC), National Alliance of Peoples Movements, Mumbai Grahak Panchayat, Shahar Vikas Manch of Mumbai, Kokan Vikas Sangharsh Samiti, KRRS (Karnataka), the Nimad Malwa Mazdoor Kisaan Sangathan (Madhya Pradesh) and others. Significantly, more than 200 Panchayat representatives from Tamil Nadu and Andhra Pradesh have already written to the Prime Minister.

As a part of the "built-in-agenda" of the World Trade Organisation (WTO), the GATS was reopened for negotiations by the beginning of 2000. From the arduous negotiations on modalities emerged a non-multilateral mechanism known as a "request-offer" approach for proceeding ahead with negotiations under the GATS. Member countries of the WTO were asked to make "requests" to other Member countries, which include: (a) the sectors that they want the other Member(s) to open up to liberalisation; (b) the mode of service supply to be opened up under that Sector; and (c) the quantum of liberalization that needs to be carried out under each mode of supply within that sector. The Members are responding to these requests by making "initial offers." This has overwhelmed most developing countries, at a time when they have been pushing the WTO to implement an assessment of impacts of services trade liberalization.

Why Moratorium on GATS offers?

GATS covers more or less all the essential public and private services supplied and consumed by society. In spite of this fact, the Government of India is not carrying out a public debate in any forum, including the Parliament, to discuss how its commitments under GATS would impact the developmental fabric of Indian society. Irrespective of the fact that a number of services get covered under the State and the Concurrent List of the Indian Constitution, several State level officials are completely unaware of the GATS itself. If this is the apathy shown by the Centre towards States, nothing better can be expected in the context of Panchayats

lib - GATS + Health Solidarity
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and Municipal Corporations. Panchayat Presidents and representatives were shocked when they were confronted with the experiences of liberalization in essential services such as health, education, sanitation and water in other developing countries.

The lack of transparency associated with the existing liberalization agenda, the undermining of federalism and the lack of competence within the Commerce ministry are some of the several issues highlighted in the letter, and underline the need for a standstill in the negotiations.

The upcoming Fifth WTO Ministerial meeting in Cancun is expected to provide the mandate for further negotiations and a deadline for final commitments. The demand from Indian civil society is that instead of accepting this process as a fait accompli the Government of India should lead the developing countries in calling for the much-needed assessment of GATS and removal of all essential services from the ambit of the GATS.

The signatories to the letter believe that the right to essential services is inalienable to all citizens of India. Further, equity, justice and dignity in the delivery of essential services is integral for long-term societal stability and equality. Signatories to the letter call upon the Indian Government to respect the Indian Constitution and fundamental principles of democracy, and act upon the concerns expressed in the letter.

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Sent: Monday, October 13, 2003 1:58 PM
Subject: India finalises initial GATS offers

Friends,
Please see the news item below. For your information and, of course, action
!
I wonder what the Indian negotiating strategy will be as the article mentions that except services all negotiations are temporarily halted. The trade off, as we all know, used to be market access for services by developing countries in exchange for agricultural concessions and Mode 4 opening by developed countries. Neither is likely to happen.
Any suggestions/ comments etc would be much appreciated
Regards,
Benny

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14/10

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Monday, October 13, 2003

The Financial Express
The Indian Express

India Readies Services List For WTO Talks
AMITI SEN

TO HRH - GATS + Health file (General Agreements on Trade in Services)

10/14/03

JN 14/10/03

10/14/03

NEW DELHI, OCT 12: The commerce ministry has finalised its initial offers list for the on-going services negotiations at the World Trade Organisation. The list is being vetted by India's WTO office in Geneva and is expected to be submitted soon.

Even as all negotiating group meetings have been suspended at the World Trade Organisation following the failure of the Cancun ministerial meet in Mexico last month, the Committee on Trade in Services is the only group which is continuing to meet.

According to sources, India is submitting offers in most areas except accountancy, legal services, post and courier services, retail and wholesale trading and franchising activities. Areas where offers are being made include communication, environment, health, education, recreation, culture, sports, business & professional and tourism.

The team led by India's ambassador and permanent representative to the WTO K M Chandrashekhar is going through the offers list finalised by the commerce ministry and giving it a final shape before submitting it to the CTS, officials said.

Interestingly, the date fixed by WTO for submission of initial offers was March 31, 2003. Till date only a handful of members including the EU and the US have submitted their offers.

Services can be supplied through four modes which include cross-border trade in services (Mode 1), consumption of services abroad (Mode 2), establishment of commercial presence (Mode 3) and movement of natural persons (Mode 4).

While India is mostly interested in Mode 4 and Mode 1 and to an extent in Mode 2, officials said that it could consider making offers in Mode 3 if there were substantial offers in Mode 4 from developed countries.

India is disappointed with the offers made by developed countries in the area of movement of natural persons (Mode 4). While the US has totally ignored the area, the EU has said that it would impose numerical restrictions on it.

On the other hand, both the EU and the US have made requests in Mode 3 as they have enough capital to establish commercial presence in other countries.

Although, all negotiating group meetings have been put on hold by WTO director general Supachai Panitchpakdi till he finishes consultations with stakeholders, meetings of CTS began on September 29.

In a special session of CTS held on October 6, a proposal on movement of natural persons jointly submitted by 13 countries including India, China, South Africa and Argentina submitted in July this year was discussed at length.

The services negotiations at WTO are taking place through a request-offer approach. Under this, all members have to submit requests to other countries in the areas where they are interested and make offers in response to the requests they have received from other members.

The offers being made have to be on a multilateral basis.

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Sent: Thursday, October 16, 2003 4:57 PM
Subject: India forsakes WTO for bilateral free trade deals

10/17/03

INTERNATIONAL ECONOMY: INDIA FORSAKES WORLD TRADE ORGANISATION FOR BILATERAL FREE TRADE DEALS WITH NEIGHBOURS

By Edward Luce

Financial Times; Oct 16, 2003

India - unfazed by the collapse of the World Trade Organisation meeting in Cancún last month - has signed three bilateral trade agreements with other Asian partners in its aftermath, writes Edward Luce in New Delhi. In spite of accusations from some that it was one of the more intransigent participants at Cancún, Indian ministers say they are happy to pursue separate deals in the absence of consensus at the WTO. Indeed, many suspect New Delhi is consciously pursuing such deals as a substitute for progress at the multilateral forum.

Last week Atal Behari Vajpayee, the prime minister, signed a free trade agreement (FTA) with Thailand, in which the two countries promised to reduce tariffs to zero by 2005 on up to 80 products. Mr Vajpayee also signed a framework agreement with the Association of South East Asian Nations (Asean) at its summit in Bali last week and recently concluded a similar FTA with Singapore.

India and Asean agreed to set up a free trade area within a decade. Senior aides to Mr Vajpayee also announced moves to set up a joint study group with Beijing to explore a similar arrangement with China. Trade between the two is set to exceed $7bn (EUR6.4bn, £4.2bn) this year, almost double the level of two years ago. "In spite of the stalemate at Cancún ... regional trading arrangements offer us im-mediate advantages," Mr Vajpayee said in Bangkok. "They can provide our domestic industry and agriculture with a valuable learning period, before being exposed to global free trade."

Some observers accuse India of precisely the same double standards that it said was shown by the US and the European Union at the Cancún meeting.

JH

Lib - Trade + Health Researcher file

17/10/03

Average tariffs in India are among the highest in the world at about 30 per cent, and it maintains higher average duties on imports from developing countries than on those from developed countries. New Delhi has also singularly failed to make a success of the South Asian Association for Regional Co-operation, which comprises India, Pakistan, Nepal, Bhutan, Bangladesh, Sri Lanka and the Maldives.

Progress towards a south Asian preferential trade area has almost stalled because of antagonism between India and Pakistan. Critics also point out that unlike Brazil or South Africa, India has done very little to reform its domestic agricultural sector to prepare for lower farm barriers. Rural infrastructure in India remains abysmal. Almost half the country's roads lack all-weather surfaces. India's farmers, who make up two-thirds of its population, are required to sell their produce to government-appointed middlemen who generally pay much less than a free market system would allow. Such restrictions keep India's farm sector uncompetitive. "India is still in the habit of empty moral posturing rather than pursuing a serious quest for a better multilateral trading system," said an Indian trade economist. "If India was serious about getting a better free trade system then it would be preparing its economy for such an eventuality."

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SOCIAL WATCH

Basic Capabilities Index 2011

Qatar

The boom and the busted

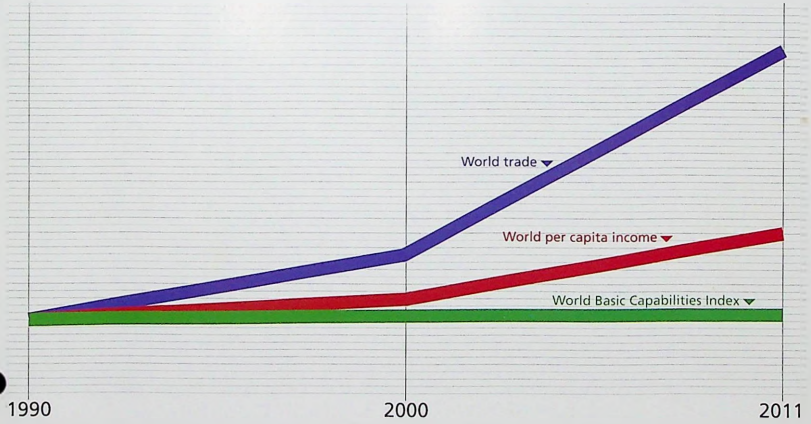
Ec-5.

A lost decade in the fight against poverty

WORLD TRADE
TOTAL WORLD EXPORTS MULTIPLIED ALMOST FIVE TIMES IN TWENTY YEARS, GROWING FROM A TOTAL VALUE OF 781 BILLION US DOLLARS IN 1990 TO [illegible] TRILLION IN 2010.

PER CAPITA INCOME
THE WORLD AVERAGE INHABITANT MORE THAN DOUBLED HER INCOME FROM 4.076 [illegible] IN [illegible] TO 9.116 DOLLARS A YEAR IN [illegible].

BASIC CAPABILITIES INDEX
THE WORLD AVERAGE IN THE INDEX OF ESSENTIAL SOCIAL INDICATORS COMPUTED BY SOCIAL WATCH ONLY GREW 10% IN TWENTY YEARS, FROM 79.3 TO 87.1.



World trade and per capita income grew faster in the first decade of the XXI century than the decade before, but progress against poverty slowed down. A gap widened, due to the unequal distribution of the benefits of prosperity. Now the boom years seem to give way to a bust. The vulnerable did not benefit from the accelerated growth in the economy, but they will undoubtedly suffer the most with a new contraction. The Basic Capabilities Index computed by Social Watch looks at basic social indicators. The 2011 figures show that economic performance and well being of the people do not go hand in hand. Progress on education, health and nutrition was already too slow when gross income was growing fast. While using the latest available figures, the Index does not capture yet the whole impact of the global financial and economic crisis that started in 2008, because social indicators are gathered and published much slower than the economic numbers. Yet, Social Watch is receiving evidence from its members on how the crisis is burdening the most those already vulnerable and that situation can only become worse if the big industrialized countries enter into prolonged stagnation or recession.

PROGRESS AND REGRESSION TOWARDS BASIC SOCIAL GOALS

The Basic Capabilities **Index 2011**

SOCIAL WATCH

- - 2011 - - - - - - - >	Child Mortality	Maternal Health	Education	Basic Capabilities Index
Afghanistan	80	99		
Albania	99	95	88	96
Algeria	97	49	82	92
Angola	84	99	61	67
Argentina	99	98	96	98
Armenia	98	99	91	96
Australia	99+	99		99
Austria	99+	89		99
Azerbaijan	97	99	92	93
Bahamas, The	99	97	90	97
Bahrain	99	18	94	97
Bangladesh	95	99+	55	70
Belarus	99	99+	97	98
Belgium	99+	95	92	98
Belize	98	78	94	96
Benin	88	72	56	76
Bhutan	92	71	70	81
Bolivia	95	99+	84	86
Bosnia and Herzeg.	99	95	89	96
Botswana	94	98	80	90
Brazil	98	99+	89	95
Brunei Darussalam	99	99+	93	98
Bulgaria	99	54	94	98
Burkina Faso	83	34	36	62
Burundi	83	44	69	66
Cambodia	91	59	64	73
Cameroon	85	99+	73	73
Canada	99	78		99
Cape Verde	97	53	79	89
Central African Rep.	83	21	38	62
Chad	79	99+	17	48
Chile	99	96	95	98
China	98	96	97	97
Colombia	98	62	84	94
Comoros	80	74	73	78
Congo, Dem. Rep.	80	86	40	64
Congo, Rep.	87	99	51	75
Costa Rica	99	57	92	97
Cote d'Ivoire	88	99+	40	68
Croatia	99+	99+	94	98
Cuba	99	99+	97	99
Cyprus	99+	99+	96	99
Czech Republic	99+	99+	91	98
Denmark	99+	93	96	99
Djibouti	91	99+	30	75
Dominica	99	98	87	96
Dominican Rep.	97	80	71	90
Ecuador	98	79	82	90
Egypt, Arab Rep.	98	84	80	90
El Salvador	98		79	91
Equatorial Guinea	86		53	66
Eritrea	95	99+	38	72
Estonia	99	6	96	99
Ethiopia	90	99+	33	58
Finland	99+	99	97	99
France	99+	86		99
Gabon	93	57	76	86
Gambia, The	90	98	44	70
Georgia	97	99+	97	97
Germany	99+	59	95	99
Ghana	93	99	61	77
Greece	99+	51	97	99
Guatemala	96	46	70	80
Guinea	86	39	42	64
Guinea Bissau	81	83	32	56
Guyana	97	26	90	92
Haiti	91	67		67
Honduras	97	99+	79	86
Hungary	99	99+	94	98
Iceland	99+	47	98	99
India	93	73	62	76
Indonesia	96	97	87	88
Iran, Islamic Rep.	97	80	89	94
Iraq	96	99+	76	87
Ireland	99+	99	97	99
Israel	99+	99	97	99
Italy	99+	98	98	99
Jamaica	97	99+	76	92
Japan	99+	99		99+
Jordan	98	99+	91	96
Kazakhstan	97	44	95	96
Kenya	92	65	78	77
Kiribati	95	97		84
Korea, Dem. Rep.	97	99+		95
Korea, Rep.	99+	99+	98	99

BCI values for 2011 were computed for 167 countries where data are available out of the 193 member states of the United Nations. The BCI values for 2011 ranged from 47.9 to 99.5 with Japan, along with Norway, Netherlands, Switzerland and Iceland, occupying the top five positions. The top performing countries having the highest BCI are mostly from the developed countries of Europe, North America and East Asia/Pacific. In contrast, the countries with the lowest BCI values are mostly from Sub-Saharan Africa and South Asia, with Chad at the bottom, along with Sierra Leone, Niger, Somalia and Guinea Bissau.

As in previous Social Watch reports, the countries are categorised into five:

Basic	BCI values 98 and over
Medium	BCI values from 91 to 97
Low	BCI values from 81 to 90
Very Low	BCI values from 71 to 80
Critical	BCI values below 70

Countries with basic BCI level are close to the maximum possible values of the indicators that constitute the Index and are very likely to have met the MDG targets way ahead of the 2015 deadline. Countries in this group are providing essential social services required to ensure a minimum dignity level and are thus able to further improve the well-being of their people.

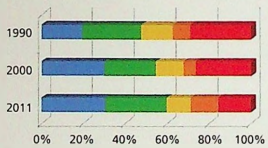
BCI Trends, 1990 to 2011 – Slowing Down

The global BCI has progressed between 1990 and 2011, altough, in general, there has been a slower rate of progress between 2000 and 2011 than between 1990 and 2000. In 1990, the average BCI value (population weighted) for countries with available data was 79.4. In 2000, BCI increased by 4.9 points to 84.3. BCI further increased to 87.1 by 2011, but at a lower increment of 2.8 points – lower than the increment posted in the previous decade.

Global BCI Trend, 1990-2011

Year	1990	Change (1990-2000)	2000	Change (2000-2011)	2011
BCI Value	79.4	4.9	84.3	2.8	87.1

BCI Levels (1990, 2000 & 2011)



Looking at the regional trends, it is noted that in the past 20 years from 1990 to 2011, more countries have achieved basic and medium BCI levels. During the same period, the number of countries with critical BCI level has decreased from 42 countries in 1990 to only 28 by 2011. Some of these countries advanced to the next level while a few have actually moved two levels higher.

The number of countries with medium BCI levels increased from 44 in 1990 to 52 in 2011. Countries that have scaled up their BCI levels from low/very low to medium include the following: Algeria, Iran, Kuwait, Saudi Arabia, Syria and Tunisia (Middle East and North Africa); Azerbaijan, Tajikistan, Maldives and Vietnam (Central, South and East Asia); and Belize, Brazil, Colombia, El Salvador, Mexico, Paraguay, Peru and Suriname (Latin America). El Salvador registered the highest increment in BCI in this group accounting for a 17 point increase for the period 1990 to 2011. In contrast, countries such as Ukraine, Bosnia and Herzegovina, and Thailand have moved down from basic BCI to medium level.

Nineteen (19) countries registered low BCI levels in 2011. Countries such as Bolivia, Honduras and Nicaragua in Latin America, and Cape Verde, Zimbabwe, and Swaziland in the Sub-Saharan Africa region, improved their standing from very low/critical BCI level to low BCI. Within this group of countries that registered low BCI levels, Bhutan in South Asia recorded the highest increase of 28 points, climbing up from critical to low BCI level.

The number of countries in the critical BCI list has declined since 1990 to only 28 by 2011. Countries such as Benin, Cameroon, Eritrea, Ghana, Kenya, Malawi, Rwanda, Tanzania and Togo in Sub-Saharan Africa; Guatemala in Latin America; Djibouti, Egypt, Morocco and Yemen in the Middle East and North Africa; Laos and Myanmar in East Asia; and Bhutan and India in South Asia, have moved up from their previous critical BCI levels. Nonetheless, the number of countries in the critical list remains substantial especially if one considers that many poor countries with no reliable

Regions	BCI 1990	BCI 2000	BCI 2011
Europe & North America	97	98	98
East Asia & Pacific	86	93	95
Central Asia	90	92	95
Latin America & Caribbean	85	91	94
Middle East & North Africa	76	85	90
South Asia	62	67	74
Sub-Saharan Africa	59	63	68
World	79	84	87

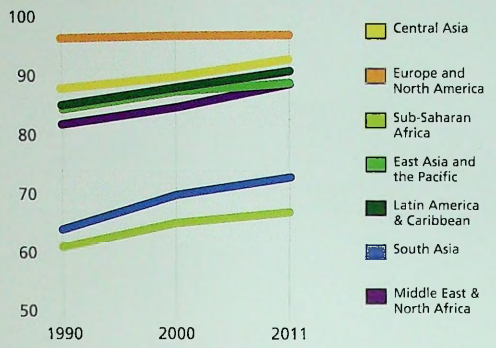
Countries			
Japan	99+	99+	99+
Norway	99	99+	99
Netherlands		99+	99
Switzerland		98	99
Iceland		99+	99
Slovenia	99	99	99
Spain	99	99	99
Korea, Rep.	99	99	99
Italy	99	99	99
New Zealand	97	98	99
United Kingdom		99	99
Canada	99	99+	99
Finland	99	99+	99
Austria	99+	99	99
France	99	99	99
Ireland	99+	98	99
Australia	99+	99	99
Greece	97	98	98
Cuba	95	98	99
Israel		99	99
Sweden	99	99+	99
Cyprus	95	98	99
Singapore		99+	99
Denmark	99	99	99
Estonia	92	98	99
United States	99	99	99
Portugal	96	99+	99
Latvia	96	98	99
Germany		99+	98
Luxembourg		99	98
Montenegro		98	98
Lithuania	99	99	98
Poland	99	99	98
Belarus	96	98	98
Slovak Rep.	99	99	98
Croatia	99	98	98
Serbia		99	98
Chile	96	98	98
Hungary	97	96	98
Russian Fed.	92	98	98
Brunei Darussalam	96	99	98
Argentina	96	96	98
Belgium	97	99	98
Czech Rep.	99	99	98
Uruguay	97	98	98
Bulgaria	98	98	98
Malaysia	94	96	98
Libya	94		97
Qatar	93	98	97
Bahrain	96	96	97
Costa Rica	92	96	97
Ukraine	98	97	97
China	92	95	97
United Arab Emirates	94	92	97
Malta	97	98	97
Kuwait	88	93	97
Romania	93	97	97
Maldives	84	90	97
Bahamas, The	97	98	97
Georgia	94	96	97
Moldova		93	96
Bosnia and Herzeg.	97	98	96
Kazakhstan	94	94	96
Belize	87	92	96
Dominica	99	95	96
Mauritius	95	96	96
Thailand	91	98	96
Albania	91	96	96
Lebanon	95		96
Sri Lanka	95	97	96
Mexico	87	92	96
Armenia	92	93	96
Jordan	91	96	96
Mongolia		92	96
Brazil	83	92	95

Kyrgyz Rep.	96	[illegible]	[illegible]	97
Laos PDR	94	99+	61	71
Latvia	99	98	97	99
Lebanon	99	62	88	96
Lesotho	92	46	62	77
Liberia	89	99+	47	68
Libya	98	99+		97
Lithuania	99	99+	95	98
Luxembourg	99+	44	94	98
Madagascar	94	54	59	75
Malawi	89	99+	57	72
Malaysia	99	95	92	98
Maldives	99	49	94	97
Mali	81	99+	46	61
Malta	99	61	88	97
Mauritania	88	99+	42	69
Mauritius	98	94	90	96
Mexico	98	99+	93	96
Moldova	98	99+	90	96
Mongolia	97	99	91	96
Montenegro	99	63		98
Morocco	96	55	67	82
Mozambique	86	37	51	68
Myanmar	93	81	70	75
Namibia	95	19	85	89
Nepal	95	99+	46	68
Netherlands	99+	99+	99	99
New Zealand	99	74		99
Nicaragua	97	33	60	84
Niger	84	39	28	57
Nigeria	86	99+	45	64
Norway	99+	99+	98	99
Oman	99	39	83	95
Pakistan	91	89	41	68
Panama	98	53	90	94
Papua New Guinea	93	97		77
Paraguay	98	83	83	94
Peru	98	62	86	92
Philippines	97	99	81	86
Poland	99	99+	96	98
Portugal	99+	99+	95	99
Qatar	99	99	91	97
Romania	99	99+	91	97
Russian Fed.	99	52	96	98
Rwanda	89	99+	57	71
Saudi Arabia	98	52	85	95
Senegal	91	99	44	70
Serbia	99	42	95	98
Sierra Leone	81	99+		58
Singapore	99+	98	96	99
Slovak Republic	99	99+		98
Slovenia	99+	33	98	99
Somalia	82	91		57
South Africa	94	99	81	89
Spain	99+	99	99	99
Sri Lanka	99	49	87	96
Sudan	89	90	49	69
Suriname	97	74	80	91
Swaziland	93	99+	75	83
Sweden	99+	99+	96	99
Switzerland	99+	95		99
Syrian Arab Rep.	98	88	87	95
Tajikistan	94	51	98	92
Tanzania	89	99	76	76
Thailand	99	62	88	96
Togo	90	98	68	77
Trinidad & Tobago	97	95	94	95
Tunisia	98	91	87	94
Turkey	98	99+	89	94
Turkmenistan	96	42		94
Uganda	87	99	62	69
Ukraine	99	99+	93	97
United Arab Emirates	99	99+	89	97
United Kingdom	99	99		99
United States	99	99		97
Uruguay	99	99+	96	98
Uzbekistan	96	95	93	95
Venezuela, RB	98	88	91	95
Vietnam	98	36	89	93
Yemen, Rep.	93	46	53	72
Zambia	86	60	67	70
Zimbabwe	91		87	82

99+ refers to a value above 99.5. It is not rounded up to "100" as that would imply a perfect accomplishment which is impossible to achieve in reality.

fall in the critical BCI levels.

BCI Level by Region, 1990, 2000 & 2011



By region, the trend also reflects the global slowdown in terms of increases in the BCI level.

There is only marginal change in BCI level for Europe and North America in the last 20 years. For the regions of Latin America and the Caribbean, East Asia and the Pacific, and the Middle East and North Africa, the trend shows a significant slowing down of progress in BCI during the period 2000 to 2011 compared to the previous decade.

On a positive note, the regions of Central Asia, South Asia, and Sub-Saharan Africa registered slightly higher increments in BCI levels in the period of 2000-2011 compared to the previous decade. Despite the higher momentum for the poorer countries in the Sub-Saharan Africa and South Asia, it must be noted that this two regions have the lowest BCI recorded. Both these regions started from very low levels, and they need to accelerate even more if they are to reach average basic levels in the next decade. South Asia is progressing faster than Sub-Saharan Africa.

BCI Trends by Component Indicators

The child mortality index has the highest values across countries and regions. The reproductive health index and education index have similar values which are significantly lower compared to the child mortality index. Globally, the 2011 population weighted average value of the child mortality index is computed at 95.7. In comparison, the corresponding value for education is 78.5 and 75.7 for reproductive health. That means more efforts are needed to address the gaps and significantly improve education and reproductive health.

The table below shows the average values of the component indicators for years 1990, 2000 and 2011 and by region weighted by population.

BCI by Component Indicators

	Child Mortality			Reproductive Health			Education		
	1990	2000	2011	1990	2000	2011	1990	2000	2011
Central Asia	92.0	94.2	96.4	96.5	93.3	97.5	93.7	93.7	93.0
Variance		2.2	2.2		-3.2	4.2		0.0	-0.7
East Asia & the Pacific	95.1	96.4	97.8	84.7	89.7	90.5	74.7	85.8	93.3
Variance		1.3	1.4		5.0	0.8		11.1	7.5
Europe and North America	98.0	98.7	99.2	97.0	96.5	98.9	93.2	94.4	93.0
Variance		0.7	0.4		-0.5	2.5		1.2	-1.4
Latin America & Caribbean	95.0	96.8	97.9	75.5	87.5	92.3	72.2	82.8	88.4
Variance		1.9	1.1		12.0	4.8		10.6	5.5
Middle East & North Africa	92.7	94.2	97.0	55.3	72.6	84.6	55.7	83.6	80.3
Variance		1.4	2.9		17.3	12.0		27.9	-3.2
South Asia	87.9	90.7	93.4	30.5	37.3	43.2	52.9	53.5	59.1
Variance		2.8	2.7		6.9	5.8		0.6	5.6
Sub-Saharan Africa	82.7	84.4	87.5	48.0	45.4	48.0	38.6	49.7	52.8
Variance		1.7	3.0		-2.5	2.5		11.1	3.1
Average	92.6	94.2	95.7	68.2	73.3	75.7	65.5	72.2	78.5
Variance		1.54	1.53		5.12	2.37		6.66	6.33

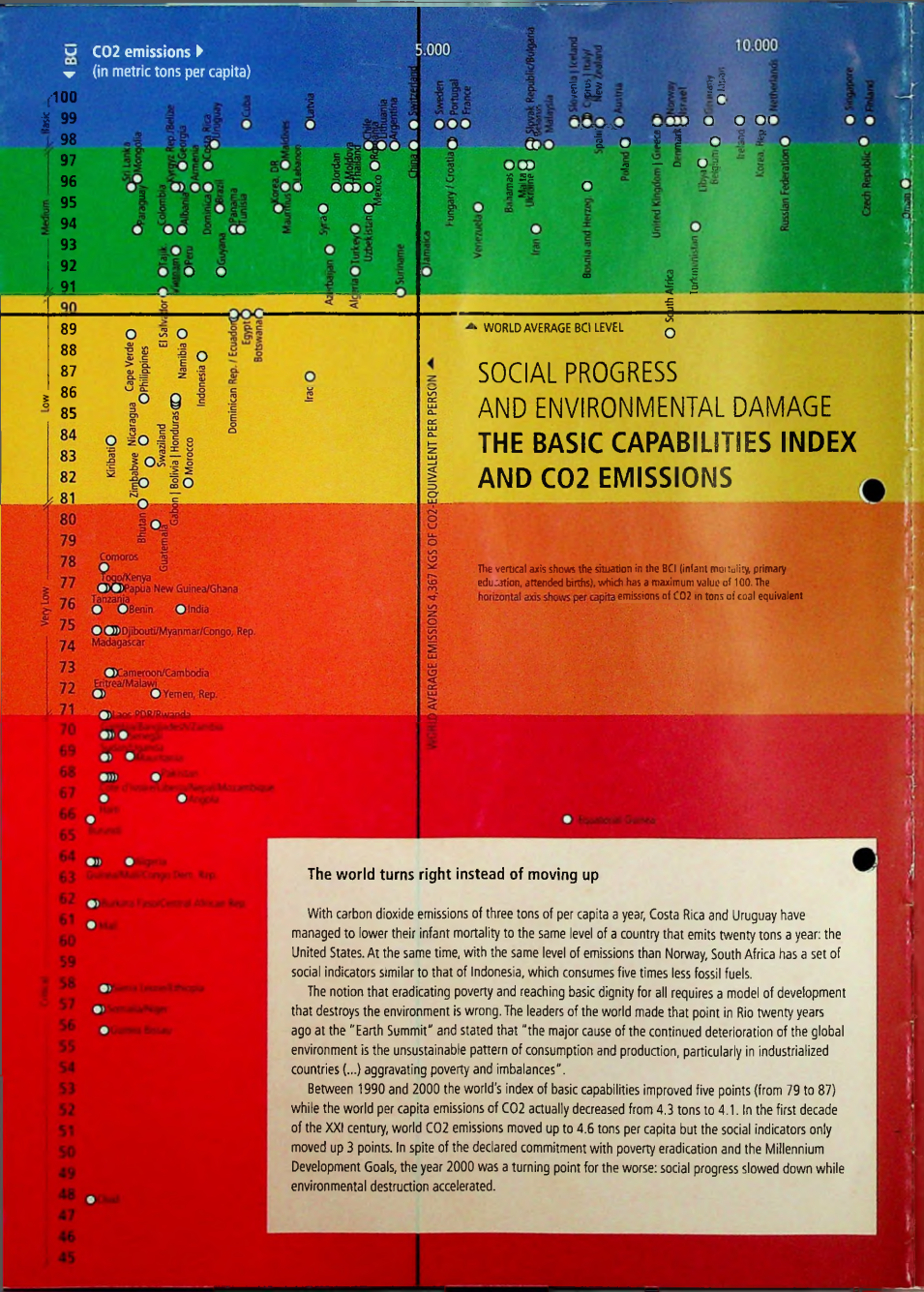
Notes:

1) All values are weighted by population

2) There may be some discrepancies in the average values of the component indicators due to the rescaling process that was used to correct for distortions due to missing data, particularly for year 1990 It should be noted that the global trends in the last twenty years for all three component indicators show a similar pattern of increases from 1990 to 2000 and 2011. However, reflecting the same pattern as the BCI, the progress is slower during the period 2000 to 2011 compared to the previous decade. That means that there is a noted slowdown in the progress achieved by countries starting 2000. This pattern is also seen in most of the regions, indicating quite a consistent trend of slowing down over the past decade.

Uzbekistan		94	95
Trinidad & Tobago	95	94	95
Oman	92	93	95
Syrian Arab Rep.	86	93	95
Saudi Arabia	86		95
Korea, Dem. Rep.	95	92	95
Iran, Islamic Rep.	82	91	94
Tunisia	86	94	94
Turkey	84	89	94
Kyrgyz Rep.		90	94
Colombia	87	86	94
Turkmenistan		91	94
Panama	92	94	94
Paraguay	83	85	94
Vietnam		88	93
Azerbaijan	89	90	93
Algeria	82	91	92
Tajikistan	80	85	92
Peru	80	85	92
Jamaica	94	92	92
Guyana	91	90	92
Suriname	88	86	91
El Salvador	74	80	91
Dominican Rep.	91	89	90
Ecuador	94	93	90
Egypt, Arab Rep.	68	85	90
Botswana	84	86	90
Namibia	81	85	89
South Africa	84	82	89
Cape Verde	78	92	89
Indonesia	74	86	88
Iraq		82	87
Honduras	72	83	86
Bolivia	74	82	86
Gabon		86	86
Philippines	83	84	86
Nicaragua	70	79	84
Kiribati	80	86	84
Swaziland	73	77	83
Morocco	64	82	82
Zimbabwe	80	80	82
Bhutan	53	66	81
Guatemala	69	73	80
Comoros		74	78
Ghana	67	67	77
Papua New Guinea	71	72	77
Togo	62	69	77
Kenya	69	71	77
Lesotho	74	73	77
Benin	50	70	76
Tanzania	64	65	76
India	63	68	76
Congo, Rep.			75
Myanmar	68	74	75
Madagascar	62	66	75
Djibouti	65	69	75
Cambodia		68	73
Cameroon	69	65	73
Eritrea	55	61	72
Malawi	55	67	72
Yemen, Rep.	56	70	72
Rwanda	57	57	71
Laos PDR	56	64	71
Senegal	58	67	70
Gambia, The	63	67	70
Zambia	67	66	70
Bangladesh	53	61	70
Sudan	75	69	69
Mauritania	60	66	69
Uganda	57	62	69
Nepal	47	59	68
Liberia		60	68
Cote d'Ivoire	60	69	68
Mozambique	46	52	68
Pakistan	56	58	68
Angola		56	67
Haiti	49	62	67
Burundi	57	54	66
Equatorial Guinea		65	66
Guinea	45	57	64
Congo, Dem. Rep.	58	59	64
Nigeria	57	61	64
Burkina Faso	52	53	62
Central African Rep.	58	60	62
Mali	41	53	61
Ethiopia	45	51	58
Sierra Leone		51	58
Niger	40	43	57
Somalia		57	57
Guinea Bissau	46	52	56
Chad	44	47	48
Afghanistan		45	

The basic capabilities index is a non-monetary way to measure poverty, based on indicators for health, nutrition and education. See the methodological details and further information at: **www.socialwatch.org**



SOCIAL PROGRESS AND ENVIRONMENTAL DAMAGE **THE BASIC CAPABILITIES INDEX AND CO2 EMISSIONS**

The vertical axis shows the situation in the BCI (infant mortality, primary education, attended births), which has a maximum value of 100. The horizontal axis shows per capita emissions of CO2 in tons of coal equivalent

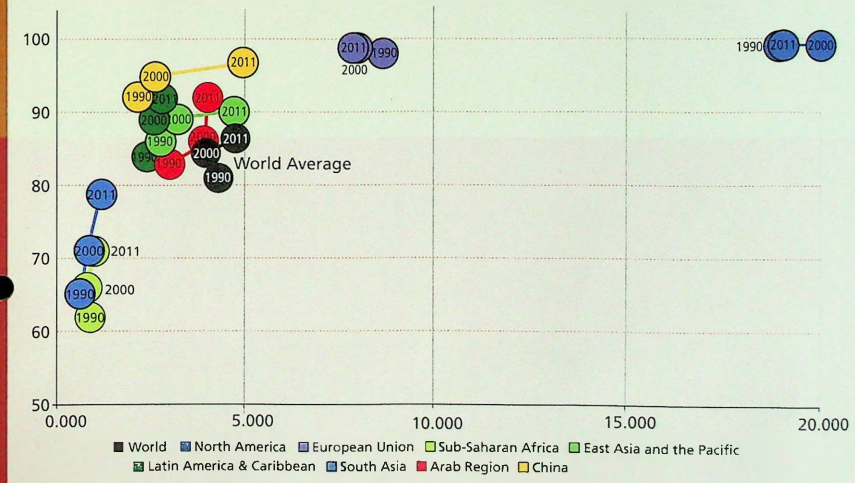
The world turns right instead of moving up

With carbon dioxide emissions of three tons of per capita a year, Costa Rica and Uruguay have managed to lower their infant mortality to the same level of a country that emits twenty tons a year: the United States. At the same time, with the same level of emissions than Norway, South Africa has a set of social indicators similar to that of Indonesia, which consumes five times less fossil fuels.

The notion that eradicating poverty and reaching basic dignity for all requires a model of development that destroys the environment is wrong. The leaders of the world made that point in Rio twenty years ago at the "Earth Summit" and stated that "the major cause of the continued deterioration of the global environment is the unsustainable pattern of consumption and production, particularly in industrialized countries (...) aggravating poverty and imbalances".

Between 1990 and 2000 the world's index of basic capabilities improved five points (from 79 to 87) while the world per capita emissions of CO2 actually decreased from 4.3 tons to 4.1. In the first decade of the XXI century, world CO2 emissions moved up to 4.6 tons per capita but the social indicators only moved up 3 points. In spite of the declared commitment with poverty eradication and the Millennium Development Goals, the year 2000 was a turning point for the worse: social progress slowed down while environmental destruction accelerated.

BCI and CO2 emissions **by regions**



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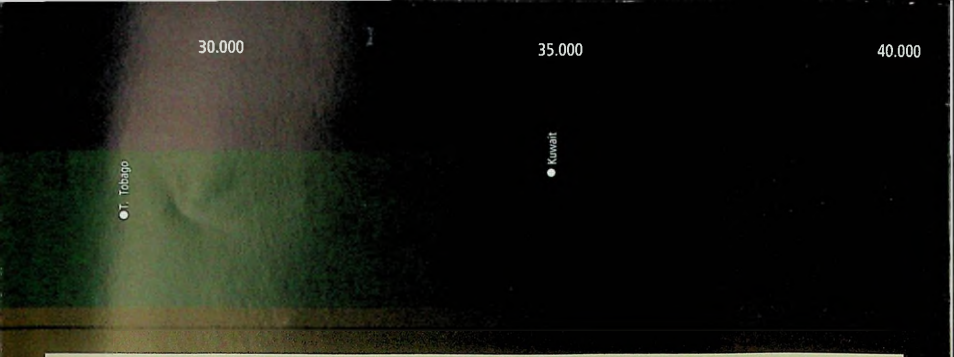

The Basic Capabilities Index: **It is not about money**

The Basic Capabilities Index (BCI) was designed by Social Watch as an alternative way to monitor the situation of poverty in the world. Most of the available poverty-measurement is based on the premise that poverty is a monetary phenomenon and they measure, for example, how many persons live with an income of less than one dollar a day. The BCI is an alternative non-monetary measure of poverty and well-being based on key human capabilities that are indispensable for survival and human dignity. The indicators that make up the BCI are among the most basic of those used to measure the Millennium Development Goals (MDGs).

The BCI assigns equal weight to three basic capabilities: (1) the capability to be well-nourished; (2) the capability for healthy and safe reproduction; (3) and the capability to be educated and be knowledgeable. The index is computed as the average of three indicators: 1) mortality among children under five, 2) reproductive or maternal-child health (measured by births attended by skilled health personnel), and 3) education (measured with a combination of enrolment in primary education, the proportion of children reaching fifth grade and adult literacy rate).

All the indicators are expressed in percentages and they range from 0 to 100. Under-five mortality, which is usually expressed in number of deaths per thousand children born alive, is expressed as 100 minus that value. So that, for example, a value of 20 deaths per thousand becomes 2% and, when deducted from 100, yields a basic indicator value of 98. Thus, the theoretical maximum value in infant mortality is 100, which would mean that all children born alive survive until they are five years old. Reproductive health takes the maximum value 100 when all women giving birth are attended by skilled health personnel. Similarly, the education indicator registers 100 when all school age children are enrolled in education and they all attain five years of schooling. These three indicators are then averaged, so the total value of the index will vary between 0% and 100%.

BCI for 2011

Countries with basic BCI level have reached a reasonable level of human development and have basically met the MDG targets way ahead of the 2015 deadline. Countries with medium BCI level have achieved a certain level of momentum to address key human development concerns and have a fair chance of meeting the MDG targets by 2015. Countries with low BCI level are still struggling to provide basic services for their citizens and will more likely miss the MDG targets by 2015. Countries with very low and critical BCI levels will certainly miss the MDG targets. Most of these countries, particularly those with critical BCI level, are experiencing severe economic difficulties, social unrest or wars. Some have just emerged from armed conflict and are still transitioning to normalize government operations and public services.

GLOBALISATION: EFFECT ON HEALTH

Late. Dr. CM Francis, President of SOCHARA

Globalization is defined as the process of increasing economic, political and social interdependence and integration. The spectacular break-through in 'Information Technology' has made the process of globalization significantly different, quantitatively and qualitatively.

Globalization also means / or seems to be occurring:

a) When multinational corporations locate themselves anywhere they wish;
b) Western Financial Institutions influence and guide patterns of 'development' everywhere; and

If:

c) National Governments cannot match the power of Transnational capital
d) The Labour of all regions is to be set in a competitive race with each other;

Then:

It is not through any existing forms of International Organizations that the poor are going to be able to defend themselves
(Adapted from Jeremy Seabook's article in Third World Network Features)

Positive implications

- Information sharing: There is the possibility that more and varied information will be available, which can be put to use by other countries. Such information will be useful in improving.
  - Services, standards and quality of care;
  - Policies;
  - Legislation;
  - Exchange of ideas;
  - Appropriate technology
- Increased awareness among people of issues and activities elsewhere;
- Better practices by health care professionals and workers.

Negative Implications

While there can be some such positive influences, the possibility of harmful effects on health and health is much greater.

Health technologies

Competition in industries often brings down the cost. But this does not happen among health care providers. It will induce the spread of newer but not fully tested technologies. This will lead to increasing investments in expensive, sophisticated technologies, which may not be appropriate for Kerala.

Public sector

To remain competitive in global markets, public expenditure has to minimize. World Bank and IMF insist that there should be a contraction of the public sector in the health care services. In India (and more so in Kerala) the public expenditure on health is already very low.

Global factors and their consequences

- 'Downsizing' and structural adjustment policies, leading to unemployment. Marginialization, increased poverty decreased social safety nets leading to higher morbidity and mortality rates.

- Increased promotion of tobacco, alcohol and psycho-active drugs, dumping of unsafe Increased addiction, ineffective and harmful treatment;

- Promotion of cash crops at the expense of food crops;
  Food security threatened; food shortage and increase in grades of malnutrition;

- Environmental degradation and unsustainable consumption by the rich;
  Resource depletion; water and air pollution; ozone depletion; accumulation of greenhouse gases; and global warming.

- Possible epidemics of respiratory disorders; immunosuppression, skin cancers; cataracts; effects of floods and storms.

Patents

The GATT agreement on Trade Related Intellectual Property Rights (TRIPS) is meant to protect intellectual property rights (IPR). It concerns mainly patents, which have serious implications on health care.

There are two types of patents:

Products patents

These patents give the holder the exclusive right to use the patented invention for a specified period of time. GATT allows a product patent for 20 years from the date of filing the patent application.

Process patents

These patents grant the holder the right s to use the process and product obtained by that process.

Indian Patents Act, 1970, recognized only process patents. IPA states that the patent should not be used as an important monopoly. It required making available the process for manufacture of the product within the country recognizing the patent. TRIPS agreement confers the right to import and does not require the production of the patented invention in India.

TRIPS provisions

Inventions in all field s of technology, including drugs, chemicals, foods, agricultural products, animals, plants, and micro-organisms are entitled to product and process patents. We have witnessed the patenting of 'basmati'.

The Indian Patent Act provided a duration of 14 years for patent protection. A patent for process of manufacturing substances used or capable of being used as food, medicine or drugs has a duration of seven years from the date of filing and five years from the date of sealing of the patent, whichever is shorter.

GATT requires 20 years patent protection for all inventions in the field of technology, 17-20 years for pharmaceuticals, which can be further increased as process patent when the product patent expires.

There is an obligation to set up production facilities in the country granting the patent. Article 29 dilutes this provision. Patentee would be allowed to import the product in the countries granting the patent; this is to be taken as on par with the obligation for production in the country that grants the patent. This would make Third World Countries merely markets for Transnational Corporations with no obligations.

According to all **legal norms,** when there is alleged violation, the accused is considered to be innocent until proved otherwise. But in the new Patent rules, the burden of proof is shifted to the accused. If a company files a suit against another of violation of copyright, the accused will have to prove his / her innocence.

Patenting plant varieties

There are many herbs which have been traditionally used in India and other tropical countries as medicines. Now, these are being taken by the affluent countries. When genetic resources are taken from the tropical countries to the affluent countries, they are treated as freely usable and knowledge of their characteristics is seen as belonging to all. When the same is processed by mixing the traits, they are treated as private intellectual property attached to them.

The same thing happens to food crops seeds. This has resulted in a few companies in the North controlling the whole of the world seed markets and genetic resources. This can affect food security.

Farmers' exemption had allowed them to keep seeds form the harvest for the next sowing. In the revised system, the farmers' exemption has been removed. If a farmer is found using a patented variety of seeds, which he does not buy, all that the agent of the patent holder has to do is to file a complaint with the concerned authority.

Farmers will be forced to buy new seeds for every sowing. The local plant breeders will have to pay royalty for using the patented variety.

TRIPS and pharmaceuticals

According to Article 70.8, pharmaceuticals and agro-chemical firms can file applications for product patents within one year of signing the GATT accord. The applicants will be given monopoly of marketing rights for five years from the date of application.

Drug prices in India were among the highest in the world before the Indian Patent Act, 1970. IPA reversed the trend. Indian companies have now become major bulk drug producers. There are about 10,000 units engaged in the production of bulk drugs and formulations. The producers could bring down the price drastically. But this situation will change drastically with the new legislation.