Embargoed to 00:01 Saturday December 10

Servicing the rich

How the EU will wreck the WTO talks

December 2005

Contact:
Katy Migiro (London): 020 7523 2058
John McGhie (Hong Kong): +44 7720 813 865 (until 20 December)

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Services: the fulcrum of a disaster?

The European Union could bring the World Trade Organisation talks in Hong Kong to its knees by continuing to exert pressure on poor countries to liberalise key services.

The long-heralded trade talks have been edging closer to disaster ever since the EU and the US refused to make any significant concessions on cutting their agriculture and industry subsidies.

Now, it appears the EU, not content with sitting on its vast subsidies, is grinding down poor countries in the services sector to such an extent that several African delegates have told Christian Aid that they are prepared to walk out of the talks rather than accept what is on offer.

If the Hong Kong talks collapse, so too will hopes of forging a new consensus on how to trade equitably in a globalised world.

Services have now become the key battle zone. Leaked documents show beyond doubt that the EU is determined to thrust aggressively for liberalisation of vital services such as banking, insurance, communications, water, environmental services and all kinds of retailing.

Pushed by a determined industrial lobby, the EU is also demanding that poor countries open up legal services, freight transport, construction and architecture, catering and travel agencies.

The list is long and intrudes into sectors where the state has traditionally played a pivotal role, providing services either for free or at reduced fees for the poor. If they are liberalised, poor countries fear they will be taken over by large multinational companies who will recoup their costs by charging fees well out of reach of the poorest people.

Hitherto, these sectors were never considered fair game for the rich nations to carve up.

Christian Aid is astonished that the EU can talk the language of development, while being so aggressive on the services sector – and at the same time giving so little up in return on agriculture or market access for poor countries.

Attached to this briefing are two clear examples of how privatising and liberalising services can radically impoverish already poor communities. Both illustrate the dangers to poor people and to developing economies of opening up certain services markets.

In **Kenya** we show how early liberalisation of private health insurance led to huge difficulties for the majority of the country's poor patients. In **Bolivia** we show how the privatisation of water caused significant problems for poor people.

Such is the sensitivity of the entire services sector that it has been 'square bracketed' – declared by negotiators to be so controversial that no agreement can be reached in Geneva. Ministers will have to fight this one out in Hong Kong, and previous experience shows that when WTO ministerials are confronted with big, unresolved questions, the consequences can be disastrous for any hope of reaching an agreement.

The last ministerial in Cancun collapsed in a welter of acrimony and mutual blame. The EU was largely responsible, after insisting that investment, competition and government procurement were included on the agenda – against the clearly expressed views of developing countries, who in the end vetoed the deal.

Now the EU is at it again. With its back against the wall on agriculture, it is trying to shift attention from agriculture to services, and to push through an aggressive liberalising agenda that will cause untold damage to the lives of millions of poor people.

For the EU, gains in services are the quid pro quo for losses in agricultural subsidies – one will not be acceptable without the other. It has tabled 106 revised 'requests' with other WTO members, indicating precisely which service sectors it wishes to see them open up.

Christian Aid has obtained leaked copies of five of these request documents, which the EU has classified as confidential. They expose its desire to ensure that European services companies gain access to and equal treatment in fragile financial and public utilities markets in some of the world's poorest nations. They also show a particular interest in banking and insurance markets and in water services on the part of the EU, revealing their attempts to cajole the WTO's least developed countries to commit themselves to services liberalisation, even though they are exempt from doing so in this round of talks.

The documents expose how, far from being straightforward trade talks, the EU is using the general agreement on trade in services (GATS) as a de facto investment agreement, as well as a means by which to break into lucrative government procurement markets in poorer countries. The EU is treating the GATS as an investment agreement because it wants to secure equal treatment for European companies and is, for instance, asking countries to scrap rules requiring companies in certain sectors, such as banking and insurance, to have a minimum percentage of domestic ownership.

And it evidently sees the GATS as a procurement agreement, because when governments open up something like the running of water supplies to public-private partnership or privatise state-owned banks, they must consider tenders from European companies equally alongside domestic businesses.

The EU has long been unhappy with the lack of enthusiasm shown by other WTO members for services liberalisation. It is ratcheting up the pressure in this area with a series of proposals that would alter agreements made at the Doha talks – effectively, changing the rules halfway through the game. This attempt threatens to bring the whole Hong Kong ministerial crashing down.

The current WTO text on services is bitterly opposed by developing countries, and is the result of strenuous pressure by the EU. The EU increased the pressure in June this year, calling for a radical change to the way the services negotiations were conducted. Unhappy with the liberalisation that other countries were promising, they called for a device known as 'benchmarking'. This proposal, dropped at the last minute, was meant to force developing countries to offer up a vast quantity of services for liberalisation. Although it has officially disappeared from the agenda, many fear it will make a reappearance in Hong Kong.

The EU was not discouraged by the negative reaction to its benchmarking proposal. Instead, informed by industry lobbyists, it switched its focus to other mechanisms to force the pace on the GATS. A letter (dated 17 November 2005) from the European Services Forum, a consortium of European services companies set up to lobby the European Community, indicates that business does not believe benchmarking will achieve its ends, but that it still wants the EU to push the liberalisation of services:

> On the particular issue of numerical targets [benchmarking], all my non-EU interlocutors were firm in the view that there was no support for this proposal from developing countries and from many developed countries, and that it would not prove acceptable to the WTO membership as a whole.

The letter then goes on to say:

> I am also aware that some ESF members fear that numerical targets would give countries the excuse to make offers in small and unimportant sectors, and leave out the larger sectors which provide more opportunity for EU services exporters.

It concludes that the EU should:

> … move on this issue [of abandoning benchmarking] soon, while we can gain credit for doing so, and focus on other parts of the Commission proposal, like the qualitative parameters and the plurilateral approach which stand a better chance of getting the result we want.[1]

This new tactic of ‘plurilateralism’ – the practice of several countries grouping together to make joint GATS ‘requests’ of single WTO members – is another device aimed at making countries go further and faster in liberalising certain sectors.

Developing-country delegates worry that plurilateralism will prove a perfect opportunity for groups of rich countries to remove the safety in numbers that is one benefit of a multilateral system; smaller countries could be picked off one by one.

According to the Hong Kong negotiating text:

> …members to whom such requests have been made, and any other interested Member, **shall** enter into plurilateral negotiations to consider such requests.

One African delegate in Geneva told Christian Aid: ‘It [plurilateralism] is much worse than benchmarking.’

What Europe wants

In the documents obtained by Christian Aid, there are cross-cutting themes which demonstrate Europe's particular interest in certain sectors.

While the EU is asking in many instances for full liberalisation of services so that European companies have 'market access' to services sectors, in many of the more sensitive sectors, such as water and banking, it wants 'national treatment' for its companies.

This uses the GATS as:

- an investment agreement, because the EC wants to secure equal treatment for European companies, and is, for instance, asking countries to scrap rules requiring companies in certain sectors, such as banking and insurance, to have a minimum percentage of domestic ownership.
- a procurement agreement, because, for instance, when governments open up the running of water supplies to public-private partnership, or privatise state-owned banks, they must consider tenders from European companies equally alongside domestic businesses.

What this means is that European services industries are likely to win the lion's share of contracts. Christian Aid's concern is that this will stifle the development of home-grown services companies in poorer nations. It will also increase the chances that profits will be exported abroad rather than retained and spent in poorer countries.

Furthermore, if such measures are forced through the WTO, poor countries will lack the ability to regulate foreign-run services markets effectively and their most vulnerable citizens could lose access to services.

Case study 1: Kenyan health warning

The very notion that healthcare services can be traded, and therefore be under the general dictates of the principles of economics, goes against the cultural beliefs and traditions of the citizens of this country. A sick person… needs help and should not be seen merely as another statistic to warrant investment in healthcare services, and for that matter liberalisation of the sector.[2]
John Kinuthia, Consumer Information Network, Kenya.

Introduction

Diana Owendi, 24, lives in a single room in Mukuru, a tin-shack slum in Nairobi's industrial area. She was raped just months before she was due to marry, leading her fiancé to call off the wedding.

When she was eight months pregnant, she started to feel unwell. On 29 September 2005, she went to Kenyatta National Hospital, the largest in Kenya. The doctor said that her unborn baby was 'placed in a dangerous way' in her womb and that she needed a caesarean section. She gave birth to a baby boy and was kept in hospital for ten days to recover.

'Just when I had healed and was preparing to leave the ward, I was told my bill was KSh20,000 (£157). I was shocked. I had only KSh5,000 (£39) – my previous month's wages.

'The hospital personnel made it clear that I either pay the bills or get detained. I explained that I had lost my job when I got pregnant because my employer was not ready to give me maternity leave.'

The hospital staff refused to let Diana go home. She was detained with dozens of other women on the maternity ward, some of whom had been there for two months. Those detained are forced to either sleep on the floor or share beds. Linen, where it is provided, is dirty. Diana mostly slept on the floor.

'I contracted a skin disease the first day after I shared a bed with somebody who had a skin ailment. It was a harrowing and agonising experience, especially since I had given birth the same month. I felt so dejected, neglected and humiliated,' she says.

The presence of several guards, armed with batons, deters most patients from trying to leave.

'Some try to escape, leaving their babies. One mother put her baby in a bag, wrapped clothes round it and escaped. She had a bill of KSh70,000 (£550),' Diana recalls.

Diana and her baby were charged KSh450 (£3.50) each to sleep on the floor. After 15 days, her bill had escalated to KSh30,000 (£236). The hospital decided to let her go if she promised to pay the remainder of the bill in monthly instalments.

'I had requested to pay instalments of KSh500 (£3.93), but they insisted that KSh1,000 (£7.90) was the minimum. I cannot pay. I have no money. Even my KSh1,200 (£9.40) rent is a problem to me,' she says.

The hospital also prescribed drugs for her newborn son – at the cost of KSh600 (£4.70).

'I didn't look at my prescription. I didn't have the money. I just threw away the paper,' she says.

A two-tier system

Diana's experience is typical of those of the majority of Kenyans who use public health services. But not all her compatriots endure these conditions.

For the wealthy, it is a different story. The richest one per cent of Kenyans, some 300,000 people, have private health insurance and access to top clinics and hospitals.

Just a few metres away from the filthy, congested public wards where Diana was detained is the private wing of Kenyatta National Hospital. Here, as the hospital's website proudly boasts, patients can choose a room complete with a telephone, television, minibar and ensuite bathroom, 'overlooking a serene garden'.[3] Crisp, freshly-washed linen is provided. Drugs are readily available. Experienced doctors are on call 24 hours a day, compared to a handful of interns rushing between hundreds of patients on the public ward.

Conscientious staff feel these differences acutely.

'Doctors get demoralised when one moment they have everything at their disposal to help the sick, only to be in a hopeless situation moments later where a patient dies for lack of equipment or drugs,' says one nurse who declined to be named.[4]

A warning to others

Kenya's health crisis provides a stark warning for those countries who are currently being asked by the EU and others to open up their markets to private health insurers. Kenya's experience of a two-tier health service has not been a happy one for its staff, far less its poorest citizens.

The EU will use December's WTO talks in Hong Kong to try and persuade other developing countries to follow Kenya's lead and open up their markets to private health insurers.

Christian Aid has established that all of the least developed countries in the WTO are being asked to deliver up their financial sectors – including health insurance – for liberalisation. And in the UK, for one, insurers and other financial service producers are poised to make significant gains as a result.

The Kenyan example shows that compelling or encouraging a country to open its markets to private health insurers can have profound and serious implications for poor people.

This paper will illustrate three key areas where having a private health scheme based on private insurance has had damaging consequences. These are regulation, 'cream skimming' and locking in.

Regulation

- As a signatory of the general agreement on trade in services (GATS), Kenya is unable to set its own cross-industry standards because the agreement demands that any regulation should not be 'more burdensome than necessary' to trade. Defining what constitutes 'burdensome' does not fall within the remit of the Kenyan government.

- The GATS inhibits Kenya's ability to do what is best for its sick people – ie compelling foreign insurance companies to insure poor and vulnerable patients. This is because, under the GATS principle of 'national treatment', the government would also have to set the same requirement for Kenya-based insurers, something it could not do because local companies would probably go bankrupt.

The Kenyan government has also lost its power to regulate profits and ensure that the money foreign companies make in Kenya stays in Kenya. The GATS say that Kenya cannot restrict the international transfer of profits, even though the government is chronically short of capital.[5]

'Cream skimming'

- This is a term given to the practice of transferring scarce resources and key personnel from the public sector to the private.

Locking in

- One of the negative consequences for poor countries committing to liberalising their services is that, if they later change their minds, it is too late; an agreement made at the WTO is binding. If a country wants to take a service out of the private sector, it can be taken to the WTO's special court by any other country who feels their trade rights have been infringed.[6]

History

At independence in 1963, the Kenyan government committed itself to providing free healthcare for all as a means to ending poverty. At first it seemed to work. Over the next three decades, life expectancy increased by 20 years and immunisation rates rose from less than 30 per cent to 79 per cent.[7]

However, by the late 1980s, the government was struggling with economic recession, corruption and a crash in the international prices of its main agricultural exports.

Under one of its structural adjustment programmes, the International Monetary Fund prescribed some free-market medicine as the solution to Kenya's financial problems. The programme called for severe cuts in health spending and the introduction of user fees – meaning that patients had to pay for treatment upfront.

Kenya liberalised its healthcare in the hope that the private sector would inject the capital that it sorely lacked.[8] The government relaxed the licensing and regulation of private healthcare providers, and also allowed public sector personnel to engage in private practice.[9]

In 1989, registration and treatment fees were introduced in government hospitals and health centres. The repercussion on the public-health sector was instant.

Outpatient attendance fell by 27 per cent at provincial hospitals, 45 per cent at district hospitals and 33 per cent at health centres. Even though children under five were exempt, their attendance fell just as sharply as everyone else's.[10] The adverse effects of the new policy were so pronounced that the government was forced to remove outpatient registration fees within a year. However, other fees were retained.[11]

With money, rather than need, determining whether a sick person received treatment, health indicators started to nosedive. The death rate of children under five shot up by more than 50 per cent between 1992 and 1998.[12] The growth of HIV/AIDS was partly to blame. But many deaths were, and still are, because poor people cannot afford simple medicines like anti-malarials, or antibiotics to combat dysentery.[13]

'Many patients opted either to stay with their conditions or sought medical treatment in the traditional herbal way, rather than pay hefty medical bills beyond their means,' says John

Kinuthia of Consumer Information Network, a Kenyan non-governmental organisation lobbying for consumer rights. 'These options made the poor more vulnerable health wise.'[14]

When Kenya joined the WTO in January 1995, it gave a signal to foreign investors that Kenya was 'open for business'. An obligation of joining was to sign the GATS, under which Kenya committed to opening up its insurance services, including health insurance. It set Kenya's liberalisation policy in stone.

Private health insurance enters the market

Health entrepreneurs spotted a new market. For those using private hospitals and clinics, private health insurance could offer protection against astronomical bills. For large corporate employers, it was a useful way to minimise the cost of providing decent medical care for their staff. For example, inpatients at Nairobi Hospital pay a deposit of £550 plus £31 a day for a bed in the cheapest ward. Use of theatre is £2 per minute. Consultation, laboratory and pharmacy fees come on top of this.

In the wake of private health insurance came health management organisations (HMOs), a concept which originated in the United States. An HMO is a for-profit organisation which offers insurance for a restricted package of care. For a fixed fee, customers can receive free treatment from an approved network of hospitals and clinics. HMOs usually have a primary care doctor who acts as a gatekeeper deciding which healthcare providers to refer the patient on to.

MediPlus was started in 1996 by a Kenyan who had recently studied health insurance marketing in the US. Within six years, he built a US$5million empire with 50,000 individual medical schemes, 200 salespeople and 80 staff. Other success stories included Avenue Healthcare (whose owner won the 1999 Best Male Entrepreneur in Kenya award) and Strategis Health.

Clearly there was money to be made. Assured by the WTO that Kenya was a safe place to invest, foreign health insurers, such as Bupa International, Allianz, Goodhealth and AXA PPP, appointed local agents and brokers to sell their services. By 2001, the Kenyan private health insurance market was among the six largest in low-income countries.[15]

The US state department recently noted that HMOs now 'dominate this sector of business and are growing at a very high rate'.

Private health insurance took off, winning some 300,000 clients in a matter of years. But there were grave problems with it.

Regulation and bad practice

In Kenya, 56 per cent of the population live on less than US$1 a day. Private health insurance is beyond the budget of all but a tiny clique of wealthy Kenyans and expatriates. But money alone is not enough to qualify. You must also be healthy. Most HMOs have a lengthy list of exemptions that exclude precisely those who need healthcare most, including the elderly and those with existing chronic conditions, such as diabetes or HIV and AIDS. Those with family planning, pregnancy-related complications and mental illness are also excluded.

'There is an inherent conflict of interest for HMOs. They minimise services offered for maximum benefit for themselves,' says Dr Rolf Korte, former director of health and education at GTZ, a German government development agency which has been working with the Kenyan health industry for many years.

As in many developing countries, regulation is weak in Kenya. Consequently clients often do not get the healthcare they thought they had paid for. Furthermore, several HMOs have collapsed in recent years, creating a crisis of confidence in the industry. In 2003, Mediplus, Kenya's second largest health insurer, collapsed with more than 70,000 members.[16] Nine creditors, mainly hospitals, took the company to court, claiming KSh81 million (£638,000) in unpaid bills. They did not get their money. Cardholding clients have been left stranded as hospitals and doctors, reeling from unpaid bills, refuse to treat them.

The Kenya Medical Association (KMA) is so concerned that it has called on the government to ban HMO's operations in Kenya.

'We have been at war with the HMOs for as long as they have been here and we have been proven right,' says KMA chairman, Dr Stephen Ochiel. 'Many of them are here to fleece the public. They literally take your money when you are well, but when you are sick they're not there to help you. They always have one excuse or another. Financial success depends on doing as little as possible to the patient.'

With hospitals and clinics transformed into businesses that had to worry about their bottom lines, their attitude to patients was also transformed. The emphasis was on making money, not curing people. Patients who could not pay their bills were subjected to inhumane treatment, such as being chained to their beds until bills were paid or made to work in hospital gardens or kitchens.[17]

Such malpractice continues today, although the current government has tried to stop it. For example, a woman was admitted to a hospital in Meru in April 2003 and gave birth to twins. As she was unable to pay the £40 bill, the hospital kept her locked up. The bill escalated to £750 after a year's confinement.[18]

Similarly, in 2004, 40 mothers were locked up for almost two months with their newborn babies because they were unable to pay for their deliveries. They were kept locked in a single dormitory where they slept five to a bed. They were only freed when a government minister, Karisa Maitha, found out and paid the bill.[19]

Cream skimming

Another widely recognised problem with the growth of private healthcare providers is 'cream-skimming'. This is where the private sector denudes public healthcare of expertise, personnel and equipment.

The WTO secretariat is aware of this risk. It has noted:

> Private health insurers competing for members may engage in some form of 'cream skimming', leaving the basic public system often funded through the general budget, with low-income and high-risk members. New private clinics may well be able to attract qualified staff from public hospitals without, however, offering the same range of services to the same population groups.[20]

In Kenya, hi-tech private hospitals in urban areas have sucked in the most experienced staff (not to mention the wealthy patients), worsening the atrophy of rural facilities where three-quarters of the population live. For example, there is one doctor for 500 people in Nairobi, but one per 160,000 in Turkana district.[21] The public health sector, starved of resources, is unable to deal with the multitude of poor and sick left behind.

Christian Aid found several cases of trained staff leaving the public health sector for better conditions in the private hospitals and HMOs. Nurse Kathleen Msaketa is one example.

‘On graduation, I was posted to a rural hospital where I was the only nurse,’ she recalls. ‘I worked without leave or off days. I was frustrated. After three years, I quit and moved into private practice. My salary doubled.’

Doctor Ndabi Wairioko also moved to a private clinic after three years in public healthcare.

‘The atmosphere in which a doctor operates contributes a lot to morale,’ he says. ‘The lack of basic working equipment and inability to assist patients because they cannot afford drugs… leads to frustration. That’s exacerbated by poor remuneration. The public service is notorious for staff shortages, and doctors there put in many hours for which they are not compensated.’

Back to the future

When a new government swept to power in Kenya in December 2002, it was determined to restore free treatment for all, regardless of their ability to pay.

The minister of health, Charity Ngilu, said:

> Thousands of Kenyans do not dare to seek treatment in clinics, health centres and hospitals as they are well aware that they cannot raise the monies for meeting the costs of treatment. How do the poor share the costs of treatment when they cannot even afford food?

Determined that healthcare would not ‘be left to market forces’, Ngilu planned that those with jobs would spend a proportion of their income on national health insurance, as in the UK. The poorest 9 million would not have to contribute anything. In this way, the rich and healthy would subsidise the poor and ill.

African Business described Ngilu’s idea as ‘one of the most exciting national health schemes in Africa’. It received widespread backing, both at home and internationally, as recognition grew that forcing people to pay for healthcare at the point of delivery discriminates against the poor and the sick.[22]

‘National social health insurance is something that’s time has come if we are going to help this country. Without health, everything else is nothing. No citizen can produce unless they are healthy,’ says Dr Ochiel of the KMA.

Three of the eight internationally-agreed millennium development goals (MDGs) for reducing poverty are health-related. On a visit to Kenya, the UN secretary general’s special adviser on the MDGs, Jeffrey Sachs, said:

> Easy access to medical care for all is what we, as an international body, strive for. Kenya has shown the way to many other African countries with this plan.[23]

The March 2005 report by the UK government’s Commission for Africa calls for African governments to stop charging for basic healthcare via user fees. It even goes so far as to recommend, ‘where African governments remove fees for basic healthcare as part of reform, donors should make a long-term commitment to fill the financing gap until countries can take on these costs.’[24]

Private fight back

However, despite widespread recognition of the need for a public health service that would meet the needs of the majority of poor patients, government plans have been stalled.

At first, it looked as if the appropriate legislation would get through parliament. Indeed, when the national social health insurance bill went to parliament on 9 December 2004, it was passed in a record 30 minutes.

But President Mwai Kibaki refused to pass it into law, and sent it back to parliament, saying the scheme had to take into account concerns of the private sector. Soon after, the Kenya Private Sector Foundation went to the high court and sought an order to restrain the government from making the scheme mandatory. It is still waiting for a date for the hearing.[25]

The law had fallen foul of a vociferous campaign led by private health insurers who did not want any opposition. The industry paid for adverts in Kenya's biggest-selling newspaper, *The Daily Nation*, calling on Ngilu to withdraw the health insurance bill. They told her to 'go back to the drawing board', arguing that 'private insurance will be crowded out' and that 'local and foreign investors will be unlikely to invest in such a climate'.[26]

Evidence of how influential the private insurance lobby was in defeating the legislation comes from an important inside source contacted by Christian Aid.

Dr Rolf Korte headed up the team from German development agency GTZ who had been invited by the Kenyan government to help with implementing a national health insurance scheme. He told Christian Aid that HMOs lobbied other influential stakeholders to win them over to their side.

'The HMOs seriously opposed this scheme,' he said. 'They used every possible channel to torpedo social health insurance. They felt this rather threatening to their own business.

'There is evidence that they had close contact with the World Bank, which took over their argument. That it would interfere with private-sector development. That public expenditure should not be increased,' he said.

The World Bank became involved in the campaign to halt the national insurance. The Bank's country director, Makhtar Diop, took an active role in publicly criticising the scheme, appearing on *Nation TV*'s *News Hour*.[27]

The KMA is also convinced that the private sector played a significant role in attacking the government's public-health plans.

'The HMOs are working day and night to make sure national social health insurance doesn't see the light of day. It's a very painful thing – a few people interested in their own pocket can sacrifice a whole nation,' says the KMA's Dr Ochiel.

However, those within the private sector remain unrepentant. Jagi Gakunju, chief executive of Kenya's largest private health insurer, AAR, admitted that there is 'an element of truth' in the argument that he opposed the scheme because it will reduce profits. But he argues 'what [Kenyans] need to do first is create wealth and more employment' before they can afford to restore affordable healthcare.[28]

Conclusion

Despite the fact that the EU is aggressively trying to persuade developing countries to follow Kenya's example and liberalise their health-insurance markets, the World Health Organisation is clear about the dangers that private insurance poses to poor people's access to healthcare.

In a report last year, the organisation specifically warned how private health insurance could lead to a two-tier service under which the poor could only suffer.

> Experience indicates that unregulated or poorly designed private health insurance systems can indeed exacerbate inequalities, providing coverage only for the young and healthy, and lead to cost escalation… In Africa… regulation of insurers tends to be weak and private insurance may lead to greater inequity and cost-escalation if it expands significantly.[29]

Another major problem for poor countries when they sign up to liberalisation of their services is that they become formally locked into the agreement. Once services like insurance have been liberalised there is very little room for manoeuvre in terms of 'deliberalising'. In other words, if countries do not like what they have done in liberalising a sector they will not be able to escape from it.

The WTO ensures that once a sector is liberalised it stays that way – whatever the consequences for the poor.

Case study 2: Bolivian water

The case of water privatisation in **Bolivia** shows the damage that the liberalisation of water services can do to poor people. The EU is currently trying to force through the WTO measures to allow European water companies to manage water systems in developing countries without sufficient regard for the impact this is likely to have on poor communities.

One quarter of the world's population has no access to clean water, which leads to the deaths of at least 34,000 people a year. The UN has warned that, unless drastic measures are taken, by 2025, 1.8 billion people will be suffering severe water shortages.

Privatisation has long been hailed by governing elites and international financial institutions as the solution to the water and sanitation crisis facing many developing countries. Yet, as the Bolivian example demonstrates, privatisation and a stringent imposition of the neo-liberal economic model has failed. People have been denied access to water – one of our most basic rights – because it has been turned into a commodity, not a common resource.

Cochabamba

The Cochabamba valley, home to Bolivia's third-largest city, suffers from a chronic shortage of water, exacerbated by rapid urban population growth and years of underinvestment. There has been a long history of conflict over water, with clashes between urban and rural users. At times of low rainfall, farmers have mounted fierce protests because their water sources have been drained by deep wells supplying water to urban residents.

Water privatisation in Cochabamba

In 1999, as a condition for a loan to the government of Bolivia, the International Monetary Fund (IMF) promoted the privatisation of public enterprises, including water. The Bolivian government granted a 40-year concession to a consortium, Aquas del Tunari, to run the state-owned municipal water company, Semapa. The largest shareholder in the consortium was International Water, which at that time was 100 per cent owned by US multinational Bechtel.

The law that facilitated the granting of the concession was rushed through congress. Immediately after privatisation, according to critics of the scheme, Aguas del Tunari raised the price of water by between 100 and 300 per cent. This is disputed by Bechtel who say the price hikes were an average of only 35 per cent.

According to published sources,[30] some water bills now come to 25 per cent of a poor family's monthly income of US$60.[31] Critics blame increases in water prices on the pressure on Aguas del Tunari to recoup its investment (so-called full-cost recovery).

The consortium was also granted exclusive rights to withdraw well water. Many poor families had dug their own wells because they could not afford to pay for piped water. With privatisation, it became illegal for anyone to use water from their own wells in areas where Aguas de Tunari offered its services.

Protests and riots broke out as the people of Cochabamba demanded cancellation of the privatisation contract. The authorities responded forcefully by putting down the demonstrations. One person died and more than 170 others were injured in the ensuing riots. But eventually, in April 2000, the government relented and broke the contract.

In November 2001, Aguas del Tunari filed a US$25 million legal action against Bolivia in a closed-door trade court operated by the World Bank.[32] Although there is heavy international pressure on Aguas del Tunari to drop the action, the case is still in its early stages and could

take up to two years to be resolved. In the wake of the Cochabamba water wars, water services in the city and surrounding areas were renationalised and returned to Semapa.

Lessons from the Bolivian experience

Christian Aid's position is that poor countries should not be forced, either by the World Bank, IMF or through the WTO, to open up their water services to foreign companies. They should also be advised clearly of the dangers of doing so. Even if government-run water services are inefficient, privatising them without reforming the government sector will almost inevitably lead to weak regulation, creating a breeding ground for abuse by corporations, including:

- higher bills for consumers, the majority of whom will have difficulty paying. By depleting meagre household resources, this increases poverty
- further exclusion of poor communities from access to basic services because they cannot afford the higher prices charged by private companies
- no increase in the service coverage to poor communities, because of prohibitive costs and the fact that services are now being provided by a corporation which exists to make a profit, rather than a government which exists to serve the people
- insufficient investment in improving the infrastructure of the water system
- potential social unrest, given the strong opposition that many people have to privatisation of basic public services

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Also of concern is the fact that if the EU was given an equal right to compete for water contracts in developing countries, as it is requesting, this would mean big European companies winning the lion's share of business at the expense of domestic water industries across the developing world.

Claire McGuigan, Christian Aid's South America trade analyst, said that an even more worrying development lies in the potential to 'lock-in' water privatisation through the WTO.

She said that if Bolivia had privatised its water company under WTO rules (rather than under pressure from the international financial institutions), they wouldn't then have been able to reverse its decision and renationalise. Including water services under WTO rules, she said, carries much greater risks for developing countries.

'The EU and other powerful blocks must not be allowed to force developing countries to liberalise their water services,' said McGuigan. 'The example of Bolivia shows the sheer misery for poor people that can result when privatisation goes wrong.'

Conclusion

What are the talks really about?

The EU and US are arguing fiercely over negligible changes to their agriculture regimes. Yet in return they are trying to extract as much as possible from everyone else. The EU has made this explicit; its last offer to reform Europe's agricultural regime came with the caveat:

> 'Europe's major partners need to understand that this offer is conditional on immediate movement in negotiations on trade in industrial goods and services as well as in other areas of the agricultural negotiation.'
> European Commission, 28 October 2005

These trade-offs are potentially disastrous for developing countries. The EU is saying to poor countries that unless they agree to liberalise vital services and lower tariffs on industrial products, they won't get the minimal agricultural reform that they have been promised. But if countries do liberalise services they will be not be able to guarantee their citizens access to the essential infrastructure – such as transport, energy and banking – that make trade possible. Furthermore, if poor countries give up the right to use industrial tariffs, they will jeopardise any chance of industrial development in the future.

Key points to look out for are:

- What happens to the draft text on **services**? The draft text put in front of delegates in Geneva, contained some highly controversial proposals. These would ratchet up the pressure on developing countries to liberalise their services sectors through the adoption of 'plurilateral approaches' and the imposition of targets. A number of countries have rejected this text. What happens to it, and to the services negotiations as a whole, will be one of the key areas of negotiation in Hong Kong.

- What happens in **agriculture**? Although the draft text is not being presented as a negotiating text, it is inevitable that there will be further negotiations on subsidies, tariffs and special provisions for poor countries at Hong Kong.

- A **'development package'**. Commissioner Mandelson has proposed six measures that the Hong Kong meeting could agree in order to solve some of the particular problems of the poorest countries. Most of this package is of quite marginal benefit – and most of it consists of things the EU is doing already, and which would only require commitments from other WTO members, such as the US. Other portions of the development package – such as the commitment to give market access to all products from the least developed countries – is not binding on WTO members and will probably not lead to any changes in policy at all.

- A package of **'aid for trade'** is likely to be a redistribution of existing aid rather than an injection of new money. And whatever aid is offered, it cannot be a substitute for the right policies and international agreements. Aid will not end the problems developing countries face in relation to trade, and should not be seen – or sold – as something which can, on its own, put the development into the 'development round'.

- What happens on **non-agricultural market access**? As with agriculture, the text going to Hong Kong is a report of the discussions rather than a negotiating text. However, it does have some numbers in it that might form the basis of an eventual agreement. This text leaves out several crucial developing-country proposals, and assumes agreement on some issues where it simply does not exist.

- **Differentiation** between developing countries. While many WTO members are happy to provide a lot of leeway to least developed countries, it is assumed by others that this should not apply to the larger developing countries, such as Brazil and India. Attempts will be made to limit the number of countries which benefit from **special and differential treatment** generally and in each area of the negotiations. While there are clearly differences between countries, it is important to remember that India contains more people living on less than US$2 a day that the whole of sub-Saharan Africa, and that Brazil's share of world trade is only 1.1 per cent. Both countries face serious problems with poverty, and both should be given special treatment at the WTO, though the detail of what they need may differ.

  Differentiation between countries should happen according to criteria that make economic sense given the particular subject on the table. Any attempt to push a more general and explicit differentiation at Hong Kong will be politically disastrous as it is already a fraught issue, viewed with great suspicion by developing countries themselves.

What would a good deal look like in Christian Aid's view?

A good deal in the WTO – whether reached at Hong Kong or many years down the line – is one that will extract big concessions from rich countries, while guaranteeing poor countries the right to use trade policy to further their development goals. Specifically, it would:

- end all forms of trade-distorting agricultural subsidies in rich countries
- increase developing countries' access to rich-country markets for all products (agricultural and industrial)
- guarantee poor countries the right to control agricultural trade to protect poor farmers and promote long-term development
- guarantee poor countries the right to control trade in industrial products to support emerging industries
- guarantee poor countries the right to control trade in services, and regulate investment in services, to ensure that poor people have access to the services they need – both public services such as health and water, and essential infrastructure such as banking.

At the moment, the prospects for such an agreement in Hong Kong look bleak. The deal on the table is the exact opposite of a development deal as it demands big concessions, especially in services, from developing countries while requiring very little from rich countries.

Christian Aid is forced to conclude that unless this position is reversed and the issue of services remedied in favour of poor countries, delegates should walk away from Hong Kong and demand that the WTO goes back to its drawing board.

Acknowledgements

This briefing was written by John McGhie, Claire Melamed, Andrew Pendleton, Katy Migiro and Claire McGuigan. With thanks to Ken Opala.

Endnotes

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Christian Aid
London: PO Box 100, SE1 7RT **Belfast:** PO Box 150, BT9 6AE
Cardiff: PO Box 6055, CF15 5AA **Edinburgh:** PO Box 11, EH1 1EL
Dublin: 17 Clanwilliam Terrace, Dublin 2
Websites: www.christianaid.org.uk www.christian-aid.ie

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