

# Challenges in maintaining and extending Sri Lanka's record on health – with special reference to international trade in services

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**Abstract** — Sri Lanka is looking to the future and planning for economic growth and development. As much as it is important to innovate and introduce new and more effective policies, it is equally important to identify, maintain and promote current good practices while informing ourselves of future challenges in areas where we could build on our successes. Sri Lanka's health indicators have been vastly superior to those of neighbouring countries, despite low expenditure on health and the long term conflict. Studies by trade and economic development experts have often pointed out Sri Lanka as an example of the benefits of public health services for human development. Yet, changes in the global economic policy environment could mean that the lessons of Sri Lanka's success story are not shared and can even be 'unlearned'. In this context it is important to consider the possible impact of the rules of the World Trade Organization (WTO), particularly the General Agreement on Trade in Services (GATS), on the Sri Lankan health policy environment - and to determine what needs to be taken into account to successfully face the challenge of promoting health policies for human development and to continue to be a beacon for the region on this matter.

*Methodology:* This paper is a legal and policy analysis. It discusses some of the possible implications of the provisions of the WTO General Agreement on Trade in Services (GATS) for policies on health services provision, especially in light of the obligation for progressive liberalization of trade in services; the human development approach; the right to development and the right to health; and Sri Lankan approaches to economic and social rights. Comparative studies of law and policy in other jurisdictions focusing on their approaches to public health services and WTO obligations will also be discussed.

*Conclusion:* Health policy-makers in Sri Lanka need to be aware of the general implications of the WTO system for health policy. The contraction of the existing policy space by making specific WTO GATS commitments to liberalize health and health related services should be avoided, if at all possible. If this can be done, it could be possible to maintain and extend good policies and practices in health services provision while continuing to be a model in this area for Asia and other developing and developed nations.

**Keywords**— Health, WTO, Human Development

## I. INTRODUCTION

After decades of war that held back Sri Lanka's economic and social development, our government and private sector can now focus on creating a more prosperous future. As noted by the report by Sri Lanka to the WTO Negotiating Group on Trade Facilitation, Sri Lanka is "an island nation which has always been a strategic trading hub in the region" (Sri Lanka, 2010), therefore the opportunities that could open up, parallel to the investment in infrastructure and the possibility of offshore natural resources, raises a lot of hopes. Kelegama (2004) notes that there is a symbiotic relationship between public and private sectors of the economy in that private investment needs public investment and the State must both regulate and creative incentives for production and innovation. This current moment is one where it is important to set in place a foundation of new and more effective policies for development.

At the same time it is equally important to identify, maintain and promote current good practices while informing ourselves of future challenges in areas where we could build on our successes. Gunatilleke (2004) commenting on "the Lessons of National Planning" in Sri Lanka has noted that Sri Lanka had taken into account and implemented the elements of the three main value systems that are part of the current discourse on development, but that it is still necessary to find the best framework for a State-Private Sector-Worker partnership that can promote a "participatory equitable social order". The three main value systems abovementioned are (1) the positivistic value system that promoted market freedoms and efficiency (2) the normative holistic approach to human development and (3) the rights-based approach linked with economic and social rights. When it comes to the focus area of this paper, the health service sector, it can said that Sri Lanka has managed to balance all three of these values fairly well, considering the resources constraints faced as a developing country.

Indeed, Sri Lanka's health indicators have been vastly superior to those of neighbouring countries, despite low expenditure on health and the long term conflict. Sri Lanka can take a leadership position with regard to health policy,

not only in the South Asian region, but also internationally. The reason for this success has been identified as attributable to the national policy of free public healthcare provided close to the client (De Silva, 2004). Studies by trade and economic development experts have often pointed out Sri Lanka as an example of the benefits of public health services for human development. This includes references by Nobel Prize-winning economist Amartya Sen in several instances including in the seminal work *Development as Freedom* (Sen, 1999). The study by Anand and Ravallion (1993) on public services highlights the positive impact of public health spending: and with reference to their key case study they also state that “Sri Lanka’s impressive record of progress in human development despite being a poor country also illustrates what the right sort of public action can achieve independently of income growth”.

The current government Health Master Plan (Ministry of Health, 2003) reiterates a firm political commitment to equity in healthcare more than once - and referring to the cultural-historical idea that health is a responsibility of King and State, adds that “For historical and cultural reasons, no matter which party is in power, health services seem to receive priority in Sri Lanka”. The current National Health Policy of the Ministry of Health (2011) also reiterates equity and accessibility and providing basic healthcare free of cost at the point of delivery through state institutions. President Mahinda Rajapaksa has highlighted this connection of the past with future goals at the 2010 UN Summit Millennium Development Goals, highlighting that Buddhist traditions guide the Sri Lankan approach to economic and social policy making (Government of Sri Lanka, 2010)

Indeed, in our eagerness to rush towards economic growth, the social aspect should not be forgotten, especially since we have achieved targets such as the Millennium Development Goals due to good social policy planning and not as a result of increased expenditure or high income. Furthermore, The UNDP Human Development Report (2010) and other academic studies (Bourguignon F et al, 2009; Baldacci E et al 2008) also note that there is no real correlation between *per capita* growth (or income) and non-income goals and indicators e.g. life expectancy and other indicators expressed in the Millennium Development Goals, without other development-supportive policies and good governance. Even the WTO Secretariat in a Background Note on Health and Social Services (1998) cites Sri Lanka with regard to health expenditure stating that “For example, Sri Lanka recorded an estimated life expectancy of 73 years in 1996, which is several years longer than in some other countries spending 20 or 30 times more on health. With Sri Lanka’s per capita expenditure on health estimated at US\$12 per annum”.

Ironically, less overall spending on health (but policies that direct benefits to the population, especially the poor) may in certain situations actually achieve higher standards of

health - something that needs to be taken into account in policy planning. Furthermore, the statistics prove that public spending on health services has greater health outcomes, especially in terms of improved health for the poor (Gupta et al 2003). Comparative studies of law and policy in other jurisdictions regarding public health services also show this. Some examples are correlation between democratic good governance and improved healthcare in the State of Ceara in Brazil (Atkinson, 2002). More well-known examples are the results shown in Cuba and nearby Kerala. Canada has a strong public healthcare system with a core principle of free and universal access to publicly insured health care due to the electoral success of the Co-operative Commonwealth Federation (CCF) party in the Saskatchewan, whose universal healthcare plan (first suggested in the 1930’s) was later taken on by the Federal Government (Duncan et al, 2010). Another example is the National Health Service system implemented post-World War II in the United Kingdom.

Yet, changes in the global economic policy environment could mean that the lessons of Sri Lanka’s success story (and those of the other jurisdictions abovementioned) are not shared and can even be ‘unlearned’. Our experience has shown that a strong public health system and free education alongside opportunities for private investment is the best way ahead. Yet even with the available facts, some economists still rely on the old efficiency arguments to devalue public health services in favour of promoting free market values in health services (World Bank/ Filmer et al 2000 and World Bank/Filmer et al 2002). The World Trade Organization (WTO) system that provides the free market legal framework for international trade in goods, services, intellectual property and other related areas such as government procurement and subsidies, could affect health policy-making and perhaps also, in the absence of competent policy-making, health outcomes as well. The impact of the intellectual property rules concerning pharmaceutical patents on access to medicines is one of the well-known controversies relating to the WTO: however, this paper will focus on health services, which are included under the WTO General Agreement on Trade in Services (GATS). Sri Lanka is a Member of the WTO and has accepted the “package” of WTO trade agreements including the GATS.

## II PROGRESSIVE LIBERALIZATION OF TRADE

It is important to consider the possible impact of the rules of the World Trade Organization (WTO) on the Sri Lankan health policy environment – in particular the possible implications of the provisions of the WTO General Agreement on Trade in Services (GATS) for policies on health services provision. But can the approach Sri Lanka has followed thus far with regard to health policy find space for expression within the current framework of rules in the WTO, specifically in the GATS?

The WTO is often referred to as “an organization for liberalizing trade” both in its own publications (WTO, 2011) and in a less positive tone, by its critics. Yet, the concept of trade liberalization is often, controversially, linked with *laissez faire* in the minds of some observers. For example, Edwards (1993) has commented that while liberalization has been referred to in various ways ranging from merely reducing trade barriers to *laissez faire*, by the late 1980’s policy debate had become both confusing and ideologically biased due to the inability to clearly define both the concepts of ‘trade liberalization’ and alternative policies to it.

Furthermore, the WTO Agreements identify the goals of the system primarily in terms of economic growth. The Preamble to the Marrakesh Agreement establishing the World Trade Organization refers to the objectives of the growth of real income and demand and expanding the production of and trade in goods and services. The Preamble to the GATS refers to the expansion of trade in services and promoting the economic growth of all trading partners through progressive liberalization of service sectors. The underlying assumption, based on classical economic theory, is that these economic objectives can be best achieved by a liberalization framework such as that promoted by the WTO.

The problem that can be identified here is that insufficient attention on the objective of sustainable human development and social equity. It has been argued that trade liberalization is the ‘handmaiden of growth’, but not necessarily the ‘engine of growth’ as it “indirectly constrains the state from going beyond the bounds of necessary public action for the provision of those domestic public goods that are essential for development” (Deepak and Rajpatirana, 1987). Furthermore it has also been pointed out that it is doubtful to what extent liberalized international trade affects income and standards of living as there is no clear evidence of a causal link – whereas other factors such as a countries’ geographical characteristics, level of internal trade and other policies have shown a significant link to its levels of growth and income (Frankel et al, 1999; IMF/ Billmeier et al 2009).

Outgoing WTO Director General Pascal Lamy, noting that public opinion has become “considerably more anxious about the effects of globalization”, has admitted that: “Indeed, it can be argued that in some instances, globalization has reinforced the strong economies and weakened those that were already weak... Some people are no longer convinced that a rising tide of trade will lift all boats” (WTO News, 2007). But he also helpfully points out that “The WTO does not produce equity, in the meaning given to the term by public international law - rather, it produces legality” (WTO News, 2006). The attempt to provide legality as an alternative to anarchy is indeed the great thing about the WTO. But who amongst us actually

wishes to exchange anarchy for international trade law *without* fairness and justice?

### III. THE HUMAN DEVELOPMENT APPROACH AND THE RIGHT TO HEALTH

There exists a broadly accepted view of achieving equitable development that is used in the international context and that is the *Human Development approach* pioneered by Mahbubul Haq and Amartya Sen. Using the language of Nobel Prize winner in economics, Amartya Sen, we can ask whether this framework for international trade and economic development can be directed towards improving “human capabilities” (Sen, 1999) across the world, and in an equitable way, not merely as an aggregation of benefits to limited geographical areas or limited social classes or communities. The role of services delivery, especially health and education, cannot be overstated in this context. For a satisfactory delivery of distributive justice and sustainable development, the social and economic system must have the support of political and legal institutions committed to delivering equitable results.

This concept is now part of the UNDP work through the Human Development Reports (HDR). The definition and parameters of human development are flexible and can evolve over time, but some of the central issues are social progress, equity, participation and freedom (equality rights and democratic governance), sustainability (ecological, economic and social) and security (similar to ‘freedom from want’). Economic growth is important, but in so far as it is a means to reduce social inequality and directly benefits the poor and marginalized groups in society, not as an end in itself. As noted by Anand and Ravallion (1993) “The human development approach focuses on the state of existence of people - the lives they lead - not the detached objects they happen to possess”. The authors also contrast the 1990 Human Development Report (UNDP, 1990) and the 1990 World Development Report (World Bank, 1990) for the differing emphasis on economic growth/income as poverty reduction instruments. The HDR definition of development, they conclude, is more consistent with the ‘capabilities approach’ advocated by Amartya Sen. The 2010 Human Development Report (UNDP 2010) also supports the idea of different means to the goal of human development and points out that research has not shown “a significant correlation between economic growth and improvements in health and education”: but that progress depends on how countries used development policy, their institutions and differences in the underlying social contract.

The *Declaration on the Right to Development* which was adopted by UN General Assembly in 1986 is also relevant. The principles contained in this Declaration include the State obligation towards a process of development wherein economic, social, cultural, civil and political rights can all be realized and most importantly, at Article 2(1)

reminds that “The human person is the central subject of development and should be the active participant and beneficiary of the right to development”. It is unfortunate that sometimes the real effects on the lives of human persons are overlooked in statistics on trade and economic growth, but human rights regime is there to redirect our focus back to this. Article 8(1) of the Declaration specifically notes that “States should undertake, at the national level, all necessary measures for the realization of the right to development and shall ensure, inter alia, equality of opportunity for all in their access to basic resources, education, health services, food, housing, employment and the fair distribution of income.”

The Right to Development has been included in all major UN documents including the Vienna Declaration and Programme of Action which was adopted by the 171 States attending the World Conference of Human Rights in 1993. Paragraph 10 of the Vienna Declaration noted that “Lasting progress towards the implementation of the right to development requires effective development policies at the national level, as well as equitable economic relations and a favourable economic environment at the international level”. The Right to Development can be read together with binding obligations found in the International Bill of Human Rights (the International Covenant on Civil and Political Rights and the International Covenant on Economic Social and Cultural Rights 1977) that has been ratified by a majority of States. The right to health, which is relevant for health policy is Article 12 of the ICESCR and states: “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health... The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: ...The creation of conditions which would assure to all medical service and medical attention in the event of sickness.” The right to health is also included in many different international and regional legal agreements and political commitments.

The General Comment (No 14 of the Committee of Economic Social Rights) further clarifies the State obligation under Article 12. With regard to the abovementioned right to health services, the political decision-making relating to the right to health is one of the highlighted issues. The General Comment reminds that States of the importance of a participatory democratic process from grassroots community to parliament for the development of the health sector. The Committee has also found that the obligations of States under the ICESCR include refraining from measures which would take a step backwards with regard to fulfilling the right to health.

The 2002 Report of the High Commissioner for Human Rights on Liberalization of Trade in Services has commented on the need of a human rights approach to keep track of

the WTO rules to avoid possible retrogressive measures. The Special Rapporteurs of Globalization (Oloko-Onyanga & Udagama, 2000) note with concern the problematic relationship between implementing the rules of the WTO system and the realization of human rights. The WTO has mostly avoided references to human rights terminology, and in the case of health may refer to ‘public health concerns’ but never to a ‘Right to Health’. The assessment and response to the impacts of the WTO on Right to Health in the human rights-related regimes (especially at the highest level) has also been disappointing at times. In 2002, the WTO and the WHO published a joint study on WTO agreements and public health which does not mention the Right to Health (which is a legal right and State obligations as abovementioned) but only ‘public health’ as a legitimate policy issue.

#### IV. POLICY SPACE IN THE GATS

It is true that there is a limitation of flexibility for members that sign up to the GATS, in so far as they agree to the main general principle of most favoured nation treatment (MFN) that applies to all members and to all services covered by the Agreement; and as far as they undertake specific commitments for national treatment and market access for services in the individualized country schedules. National treatment and market access in the GATS depends upon the scheduling of commitments each member makes for particular sectors and sub-sectors. It seems that the WTO system is not so rigid as to completely prevent opportunities for policy flexibility and this was probably not the intention of the drafters of the WTO Agreements either. As stated during the Uruguay Round negotiations in the Ministerial Declaration of 20 September 1986, the multilateral framework of principles and rules for trade in services “shall respect the policy objectives of national laws and regulations applying to services”. The Preamble to the WTO Agreement also refers to the social objectives of raising standards of living and ensuring full employment and the Preamble to the GATS refers to “due respect to national policy objectives” and the desire to the strengthen of developing country domestic services capacity and their efficiency and competitiveness.

The issue is whether this *respect* translates into something concrete in legal terms within the framework of the GATS. Is it possible, within the available flexibilities, to take measures according to national policy objectives which run counter to the GATS obligation to liberalize trade in services? The GATS Agreement Article XXVIII(a) (Definitions) states that “For the purpose of this Agreement:...“measure” means any measure by a Member, whether in the form of a law, regulation, rule, procedure, decision, administrative action, or any other form.”

Focusing on the area of health services, it can be asked whether measures taken that are in line with the state obligation under international human rights law, in

particular the abovementioned right to health in the International Covenant on Economic, Social and Cultural Rights, would be affected negatively or given protection in the WTO GATS System. The Committee on Economic, Social and Cultural Rights has noted that the undertaking to take all appropriate steps for achievement of rights in the Covenant “neither requires nor precludes any particular form of government or economic system being used as the vehicle for the steps in question...only that it is democratic and respects all human rights” (Office of the High Commissioner of Human rights, 1991). This view was reiterated in the Limburg Principles on the Implementation of the ICESCR (1986), which stated that “the achievement of economic, social and cultural rights may be realized in a variety of political settings. There is no single road to their full realization”. In the case of health services, there is some evidence that health indicators and equitable access have a correlation to the health system that is in place (WHO, 2007; Marmot, 2005) but there is no evidence that a liberalization of health service contributes to better health indicators. Therefore, a rush to a worldwide single liberalized model of health services seems a bad idea – and allowing the current plurality of systems to exist while studying the outcomes should go on for some time longer. The end of the Cold War should *not* be confused with an end of the debate on choice of economic model for the provision of services (particularly essential services such as health) and an automatic adoption of identical free market-type profit-oriented models in every sector. Krajewski (2003) also states that the fundamental differences in health services regulatory frameworks in different countries and the insistence of many countries to maintain their current trajectories, means that agreement on a single model for liberalization unlikely.

#### V. CHALLENGES OF THE GATS

In the context of international trade in services, there is a fear that the WTO GATS will tie the hands of nation states and local authorities, limiting future policy flexibility that is necessary for progress and achieving socio-economic goals. This fear is especially acute in the case of the GATS because the influence or intrusion on domestic governmental decision-making and action is considered more than earlier GATT rules (Kennedy & Southwick, 2002) and most people reading the GATS find themselves confused and lost in the maze of the provisions, their differing interpretations and the possible loopholes. Some observers have linked the lack of improvement or deterioration in public health service delivery in different countries and the increase in healthcare costs with the implementation of a market-based approach to services via the GATS coupled with a corresponding neglect by the State of its Right to Health obligations.

Article 1:3 of the GATS is referred to as the ‘public services exemption’ of the GATS as it seems to exempt public services

(“services in the exercise of governmental authority”) from the scope of coverage of the Agreement. However, this provision is not clear and has not been authoritatively interpreted. The opinion expressed by many trade lawyers is that it cannot exempt all public services (Krajewski, 2001; Adlung, 2005) as according to Article 1:3, there is a requirement that governmental services will be exempt only if they are neither “commercial” services nor “in competition with” other service suppliers. Adding to this is the fact that future WTO disciplines in the negotiating areas of domestic regulatory autonomy and subsidies have the potential to negatively impact the freedom of national health policy-making on public health services. If Sri Lanka wants to show leadership in this issue – it is necessary to stay alert about the negotiating mandates of the GATS and make our voice heard; instead of leaving the matter of public services-friendly drafting and interpretations completely in the hands of countries such as UK and Canada where there are also concerns about the impact on the NHS (National Health Service) and Medicare systems.

As discussed earlier, the GATS is aimed only at achieving progressively higher levels of liberalization of trade in services. This process of liberalization is to be conducted either through successive rounds of trade negotiations or autonomously by each WTO member. The trade negotiations in the WTO are carried out on parallel multilateral or bilateral tracks. There is a lot of comment on how flexible and non-coercive GATS obligations are, as members decide on whether or not to take on legal commitments on national treatment and market access for foreign service suppliers. The principle of ‘National Treatment’ in the WTO basically means that foreign companies must be treated the same as domestic firms. With regard to the GATS, this is not an obligation automatically arising from WTO membership. However this voluntary process of liberalization through “specific commitments” needs to be looked at realistically. Health services are divided up into at least three of the core sectors of the GATS - profit oriented social services (health services), business services (health workers) and financial services (health insurance). Each WTO Member has submitted a schedule of specific commitments under the GATS. Sri Lanka has not made commitments in Health services so far, so only the general obligations of the GATS that exist without reference to the schedule would apply.

Considering the difficulty of changing the commitments once made and the obligation of compensating those countries whose trade interests are harmed by the change of commitments, it is best that Sri Lanka does not take on any commitments in this area. The other step that can be taken is to accept bindings at less than status quo – so that policy flexibility is minimally affected. In the latter case it only gives the appearance that the country has agreed to more than it actually has in terms of liberalization but the some policy space is retained so that some flexibility is retained. At present, Sri Lanka’s level of GATS commitments

is very low (Geeganage, 2013) and no commitments have been made in health services.

It is often only the external affairs, trade and commerce sections of government that are involved in the preparation and negotiation processes under the GATS but it is essential that other relevant bodies, such as Ministry of Health and other stakeholder representation (e.g. health professionals, patient's rights organizations) are consulted and involved. The Sri Lanka Medical Association has an Expert Committee on Trade Services which has been analyzing the impact of GATS and other regional trade agreements for several years. The most recent consultation with the Director General of Commerce resulted in an assurance that health services will not be opened up under either the India – Sri Lanka Comprehensive Economic Partnership Agreement (CEPA) nor the SAARC *Agreement on Trade in Services (SATIS) Agreements (SLMA, 2012)*. Professional medical and dental colleges, associations and trade unions were involved in this consultative meeting which was held on 28 August 2012. It remains vital to look at both the GATS and regional services liberalization agreements, not only in terms of the effects on powerful domestic stakeholders but also to heed the voice of the marginalized sections of society, who would suffer most if essential health services are cut down, withdrawn or left undeveloped as a result of badly formulated public health and trade in health policies. It is the responsibility of experts, professionals and civil society to make those voices heard.

Realistically speaking, the pressures from economically and politically stronger trading partners should also not be discounted in efforts to remain free from trade obligations. Article XIX of GATS is titled Negotiation of Specific Commitments, which is under Part IV of the Agreement, which is titled 'Progressive Liberalization'. Thus the GATS itself sets out a framework for moving forward on negotiations for liberalization. It has been commented that the process of liberalization of services has been historically driven by US and European corporate interests in search of access to markets, and as long as this agenda is sustained, the real-world political pressures also remain (Hoekman et al, 2007). Footer and George (2005) have noted the role of the United States, European Communities, Japan and the Nordic Countries in proposing and supporting the inclusion of a services round in the negotiations for the establishment of the WTO.

Opening up domestic markets to international competition does not necessarily translate into overall higher living standards for developing countries, as their limited purchasing power suggests that, in many cases, the elite are more likely to benefit from service liberalization than the general population. This may not be the case for all service sectors: for example, greater competitiveness in the telecommunications market may drive down

prices and make telecom services accessible to a larger proportion of the population than before, as we can see in Sri Lanka. But with other services, more vital ones such as health or education, the market may not work the same way and have the same benefits. This is because not all services are alike nor will the result of market forces have similar results. Just as it is argued that the essential medicines should be treated differently from other goods and intellectual property, health services should arguably be looked at in a different light than most other services because of the magnitude and importance of its impact on those deprived of it.

There is an important issue underlying the differences between an approach to development that focuses on numbers and an approach that focuses on people, that needs to be reiterated. In the words of two trade lawyers: "As far as the theory of free trade is concerned, it has to be borne in mind that it refers to the prosperity of a society as a whole. It does not address questions about the distribution of this prosperity and the priorities of economic development" (Stoll & Schorkopf, 2005). It is for these concerns about distributive justice that national policy space needs to be retained in international trade for the policies that have been successful in delivering social justice and improving human capabilities.

## VI. CONCLUSION

In conclusion, it can be seen that Sri Lanka is facing several challenges in this period of change and transition. It is important to formulate a comprehensive national health policy for the challenges of transition and the complexities of co-ordinating public and private activity (De Silva 2004). If Sri Lanka successfully faces the challenge of promoting health policies for human development in this globalized and liberalized age, we can continue to be a beacon for the region, as well as internationally, on this matter. Health policy-makers in Sri Lanka need stay aware of the general implications of the WTO system for health policy. All possible interpretations of WTO law that protect public health services and promote pro-poor and pro-development health policies should be supported. Making specific WTO GATS commitments for market access and national treatment to liberalize health and health related services should be avoided and the Health Ministry (and stake-holders in public health services) must work closely with other government Ministries and Departments, particularly the Foreign Ministry and Commerce Department, to maintain the required policy space the policy space in trade in services. The available expertise on the topic of Sri Lankan health policy should also be utilized to the fullest extent. If this can be done, it could be possible to maintain and extend good policies and practices in health services provision while continuing to be a model in this area for Asia and other developing and developed nations.

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