

***The Current Trade Paradigm and Women's Health
Concerns in India: With Special Reference to the
Proposed EU-India Free Trade Agreement***

Executive Summary

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Executive Summary

India is currently negotiating a Free Trade Agreement with the European Union, which includes not only liberalisation of commodity trade, but also a wide range of chapters including deep services trade liberalisation, full investment liberalisation, and stricter IPR conditions than the TRIPS norms. As trade is an engine of growth and development, India's trade policy has many goals to meet. India shows high poverty level, increasing income and social inequalities as well as deep seated gender inequalities that trade policy cannot bypass.

Health is an area of special concern in the context of gender inequalities. Arguably, where there is a constraint on health care access, whether due to education, income or location, women experience a greater constraint compared to men. Since the EU India FTA covers many areas which are known to have serious implications for health, this needs detailed analysis. Liberalisation of health services coupled with investment liberalisation, TRIPS plus provisions in the IPR chapter are some concern areas and can affect the access to medicines and treatment, as well as to food. In addition, the way deep trade liberalisation uses women's labour and imposes adverse working conditions on them is another aspect which must be taken into account. Domestic policy space at the disposal of the Indian government to address gender inequalities and change the social structure can also be affected by the FTA. Therefore, an analysis and evaluation of health impacts of this FTA on Indian women is necessary. The need to indicate suitable policy interventions, both in the trade agreement and in the domestic socio economic environment, to maintain and encourage women's access to health and healthcare, is undeniable. This study is an attempt to provide such an analysis in simple terms.

A Gendered Look at Health Indicators in India

Interestingly, if we compare India's health indicators to that of the European region, the gap is enormous. Among cause specific mortality rates, maternal mortality rate in India is 16.6 times, TB among HIV positive population is 2.8 times, and age standardized mortality rate from non communicable diseases is 1.2 times the comparable indicators in Europe. Only the incidence of cancer in India is significantly lower than in the EU.

Women's socio economic achievement, in particular, remains a matter of concern in India, which, despite efforts from many sectors, still lags far behind that of men. Their constrained access to resources, both physical and human, in terms of land, water, capital, health and education, is evident even from a cursory glance at gender based data. Literacy rate is 53.67 compared to 75.26 of men, and work participation rate 25.6 compared to 57.9 for men (2001 Census). Women seem to contribute only 17.2% of organized sector employment in 2001.

Health is an area of special concern in this context. While gender based health indicators have shown improvement over the past, the achievements are still far from optimal. While life expectancy has improved from 58.1 in 1990 to 65.3 in 2001, this seems to be the only indicator which is better than that of men. Infant Mortality Rate (IMR) for women is 65 to 62 for men, the sex ratio is still 933 (2001 Census).

Maternal care in India has definitely improved in India since 1992-93, but with only 76% women accessing any ante natal care and only 40.85 of births happening in a health facility, there is a long way to go. There is also a clear rural-urban gap in maternal care in India. Though incidence of cancer is still low in India compared to developed countries, incidence of breast and cervical cancer, apart from other forms of cancer, are becoming increasingly significant. According to NSS data (2004), out of every 1000 women, 33 in urban areas and

39 in rural areas were hospitalized due to cancer. Even in case of HIV/AIDS, a largely male dominated disease, Indian women are increasingly becoming victims. Pressures of migration, violence against women including trafficking and domestic violence are sources of this problem which in turn subjects women to HIV/AIDS risk. Lack of information and denial of access to safe practices during sex are additional reasons for this situation.

From a survey of health indicators of women in India, it seems evident that location (rural/urban) has a significant role to play in its determination. The traditional structure of rural societies, the lack of general access to health facilities, coupled with a lack of education and employment opportunities, translates into a severe restriction on health improvement opportunities for women in rural areas. Education, employment and general income class all appear to play significant role in empowerment of women and therefore, in the determination of health conditions for both rural and urban women. Inequalities in income also have a direct impact on access to health services. The lack of access to food and nutrition also has significant impact on women's and children's health in India. This is also reflected in the high rate of anaemia, goiter (due to lack of iodine), and high rate of underweight children in India. Therefore, gender inequalities in health indicators are significant and seem to be strengthened by income, regional and social inequalities (social relations) and a number of issues need to be kept in mind for proper redress.

Given this situation, it is important to note that any further constraint on access to medicines and to cheap and widely available healthcare facilities will act as a stronger barrier for women and create worsening impacts on already significant inequalities in such access.

TRIPS Plus Provisions and Access to Medicines

Restriction of pre grant opposition, data exclusivity or protection of trial data, patent market linkage, patent term extension, constraints on compulsory licenses and parallel imports, ever-greening, are some of the TRIPS plus provisions likely to be contained in the EU-India FTA, which can severely impact access to critical medicines and treatment. By making generic production more costly or delayed, in effect, the price of medicine is increased, in addition to the delay in supply of critical medicines at affordable rates in developing countries.

Data exclusivity, or strict restrictions on usage of trial data notwithstanding whether a patent is granted, has been a key demand of EU in this FTA. This implies that national regulators cannot refer to trial data submitted by the original applicant to grant marketing rights to a generic producer for a certain period of time, usually 5-10 years. In EU this is 10 years. This implies that generic producers will now have to submit their own data and therefore will have to repeat clinical trials if they have to enter the market within this period. Not only is this costly and often unaffordable for small producers, it also involves unethical wastage of resources in repeating trial of already established treatment. In Jordan, data exclusivity as a part of the US-Jordan FTA has raised medicine prices by 2 to 6 times (Oxfam 2007).

Patent term extension to beyond the TRIPS' stipulated 20 years, and patent linkage are other controversial inclusions that impose further constraints on medicine supply and prices. In addition, EU's keenness to enforce 'border measures' which are a set of provisions which relate to IP enforcement threatens the health of not only Indian citizens but of the vast majority in developing countries who receive supply of cheap generic medicines from India. Finally, limitations on the use of TRIPS flexibilities such as the use of compulsory licenses and parallel importation, deny developing countries the right to protect public health.

The reach of TRIPS plus conditions covers traditional medicines and forestry products as well, which make it difficult for rural and indigenous communities to continue to use and protect such systems of healthcare. Women often act as main keepers of traditional knowledge, and benefit from both the sale and use of traditional medicines, thereby protecting the health of their families and communities. All over India and the developing world, women plant, transplant, and maintain trees, collect fruits, oils, and medicines from trees to use in the home or sell in local markets, and maintain subsistence farms and traditional agro-forestry systems. The TRIPS plus conditions also contradict the efforts made by India to develop an effective National *sui generis* system.

In India, there is already a sharp difference between the prices of drugs produced by branded companies and generic producers. This study provides several examples of such differences in medicines relevant for women, with the ratio as high as 12 or 5.5 times for some drugs. The Patent Act of 2005 has already started to exacerbate this gap. For many drugs used by women, including the ART medicines, price difference is sharp. Constraints on access to medicines are going to prove especially critical for HIV/AIDS treatment, a disease to which an increasing number of Indian women are succumbing.

As argued before, any constraint on access to medicines and public healthcare acts as a stronger constraint on women. First, women are generally economically poorer than men, both across and within households. Second, in situations of constraint in access, it is most often the women who forego treatment. For example, in treatment of critical diseases like HIV/ AIDS in couples, the woman often gives up the medicine if supply is limited or expensive. Third, as discussed, women in developing countries also practice and use traditional medicines extensively. Therefore further restrictions on such access imposed by the FTA may add up to a serious impact on women's access to medicines, and health.

Trade and Investment in Health Related Services

Services trade liberalisation can come combined with widespread investment rights under FTAs. Committing to trade under mode 2 (consumption abroad) and mode 3 (commercial presence) poses certain problems as domestic regulation of areas like medical tourism will be severely restricted and the government may be unable to bring in major changes in regulation without infringing on FTA provisions in the future. Surrogacy, for example in India, has been a much debated area where activists have asked for more regulation. Many of these issues are new issues and there is very little existing domestic legislation in many developing countries on these areas. It is also argued that medical tourism increases the constraint on access to health services for domestic citizens, especially the poor, women and children by making them share domestic supply of health services with foreigners. On the other hand, the benefit of FDI, specially unfettered, has itself been questioned. Foreign investment in foreign owned hospitals, for example, provides undue competition to domestic and state run hospitals, drives up user prices and necessitates a switch from public to private expenditure on health. It increases private facilities at the cost of public ones with cost to the poor.

Mode 4, on the other hand, seems to still remain under committed where the EU is cagey. While this may not be of much use to India's skilled women workers, e.g. nurses, the critical need of India's migrant unskilled female workers (like care workers), still continue to be out of bounds for Mode 4. However, though it means that workers and women workers cannot hope to gain much in terms of employment opportunities and labour rights in the EU, this may be a blessing in disguise for India as Mode 4 also tends to produce drain of skilled and semi skilled professionals at home.

Health Impact on Women Workers in Export Based Industries

In addition, an increasing concern with FTAs may be the direct impacts on health in export based industries. While this problem is relevant for trade liberalisation in general, now with real protection in terms of actual tariffs coming down significantly under the FTAs, competition increases manifold. Therefore, the pressure on labour force and the use of flexible labour with adverse working conditions can also increase, with significant impact on the health of its work force. Since women dominate these export oriented sectors in many of the Asian economies, including in India, this is a matter of serious gender concern. This issue has been a matter of some concern among civil societies in developing countries, especially relating to segments like textiles, garments, tobacco production, leather. While trade with the EU is expected to boost employment, job related pressures in export sectors like textiles and garments can add to adversity for women's health conditions.

The EU has asked India to conform to ILO labour standards which India is yet to ratify. India, in return, has asked EU to not raise non-trade issues in trade agreements. This represents one of the most contentious areas in the negotiations. India, along with many other developing countries, sees these as non-tariff barriers. However, it is true that tackling labour standards is complicated in a bilateral forum if other countries in similar situations do not do so, though India needs to implement its labour standards, and ensure the health and safety of its workers domestically. The EU should also ensure that it follows a uniform policy as regards its own investments in developing countries where it seems to have been much more lenient.

TRIPs plus Provisions, Access to Seeds, Food and Health

The TRIPs plus provisions on IPRs affect not only the access to medicines but access to food as well. The FTA may include a strong obligation for India to join the UPOV 1991 convention. This places pressure on India to recognize seed breeders' rights as opposed to the farmer's rights. There are other issues as well. The use of GMO seeds, often pushed by FTAs, for example, are not only fraught with health and safety questions, but also have to be bought each season, thus reducing the farmers' ability to freely exchange and reuse. The use of GMO seeds also reduces the farmer's ability to protect traditional seeds from extinction.

These combined restrictions on the use and exchange of seeds and genetic resources undermines women's role as seed keepers, users of traditional seeds and propagators of bio diversity. It obviously reduces their ability to engage in agricultural production, maintain livelihoods and food security. In fact, given lower access to knowledge, resources and skills, their ability to register and access patents and other forms of IP is much lower than even that of the ordinary farmer. Simultaneously, since women often produce for subsistence rather than the market, the higher costs resulting from such control of knowledge & technology in general and of products in particular, can be heavier on women's access to food and therefore to nutrition and health. All these provisions also impose limitations on bio diversity and encourage bio piracy.

Constraints on Domestic Policy Space

Finally, the constraint on domestic policy to regulate and intervene in the health system to address key health concerns, especially for vulnerable groups, is a matter of increasing concern. This is a cross cutting issue and comes up again and again throughout this FTA chapters. For example, government policy space to regulate domestic health conditions may be affected by the TRIPs plus provisions and its constraints on compulsory licensing, parallel

importing etc. The establishment of competition policy and full liberalization of public procurement also affects domestic country governments' ability to address inequities in health care and ensure the availability of medicines and treatment.

Health Implications for Indian Women through the EU-India FTA

This study finds that there are many likely provisions in the EU-India FTA that can adversely impact women's access to healthcare in India. Some direct impact may also be felt as a result of increased pressure on female-labour intensive export based sectors. In addition, the government's ability to address health concerns through its policy space may also be constrained. While the Indian government has apparently rejected many of these provisions (e.g. TRIPS plus IPRs), it may be forced to give in to some provisions while bargaining for others. It is of importance to resist TRIPS plus provisions like data exclusivity, patent term extension so that its generic production of pharmaceuticals and access to medicines is not compromised further. Retaining TRIPS flexibilities and using these extensively is also a policy option that India must pro actively pursue, irrespective of the FTA. It can for example, use compulsory licensing and price control more effectively. India must also resist strong and unjustified provisions on IP enforcement, in particular, border measures, as it affects not only India's domestic supply but supply of critical medicines to other parts of the developing world.

Pressures to join UPOV 1991 that works against Indian farmers cannot be justified either. In the field of traditional medicines, India has been prudent to drop provisions, and India can take a more proactive role in imposing CBD provisions on EU. At the same time, India's own Sui generis system of protection of plant varieties needs to be defended both for traditional medicines (plants) and food security. Though health services liberalisation may not be high on EU's agenda right now, India needs to guarantee access to such services to all its' people even in the future, and replacing public services with private ones is a costly solution. Foreign owned services with strong investor rights may mean further erosions of access. India also needs to protect its policy space to ensure health access to all, and be able to make suitable regulatory intervention to resolve health related issues.

India must also take a proactive role in safeguarding the health of its workers, and ensure that trade liberalization and export growth does not come at the cost of its workers health and wellbeing. Finally, gender disparity in health indicators is strengthened by existing inequalities in incomes, employment, regional divide in health infrastructure and gaps in education and social consciousness. Until these are addressed domestically, women will somehow lose out from ambitious trade liberalisation. Therefore, attaining certain minimum equality in socio economic indicators is a policy measure that India must consider seriously before increasing possibilities for further exacerbation in such inequalities through bilateral trade liberalisation. Attaining a balance between growth and equitable development, between men and women, between rural and urban areas, between metropolitan cities and other areas, and between private and public provision of healthcare should be, in some ways, a prerequisite before attempting an ambitious trade agreement. Broad-based social security programmes covering job security, income security, health and education guarantee, are proactive options in this regard. Finally, India must keep in mind the impact of its stance in the EU India FTA on WTO negotiations. India cannot afford to weaken its own position or that of developing countries as a whole, by giving concessions for commercial gains, especially ones that can harm the basic health needs of its citizens and vulnerable groups like women.