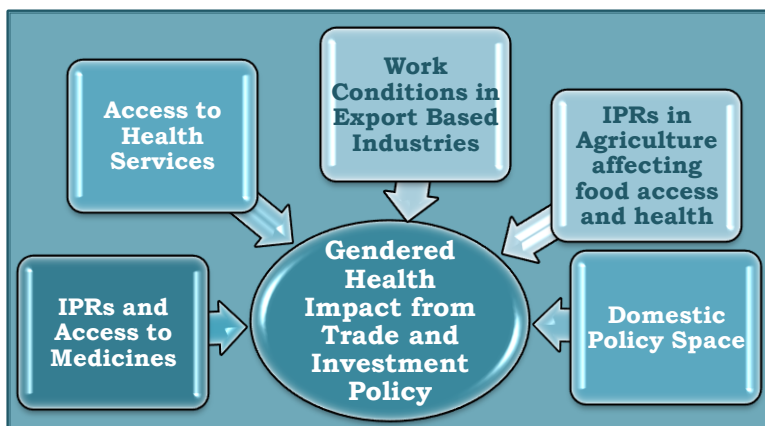


Trade Liberalisation and Women's Health Concerns in India: Some Critical Issues

Trade and *health* are two words that were not specifically interlinked in the past. But with India's increasing engagement in global and bilateral trade deals, that idea is changing fast. India's commitments at the WTO, as well as the increasing number of bilateral trade and investment agreements that it is signing, indicates that trade is not just about exchange of goods anymore. Trade policy is getting into areas which can significantly impact access to treatment, to medicines and therefore affect health conditions both directly and indirectly. But while India shows remarkable strides in economic growth, its distribution does not do so well. India shows high poverty levels, increasing income and social inequalities as well as deep seated gender inequalities, both in economic and social indicators.

Figure 1: Trade Related Impacts on Women's Health



Health is an area of special concern in the context of gender inequalities. Women's health is of great importance both for their own sake and for the sake of future generations, but paradoxically remains the weakest and the most discriminated against in most countries. 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. Specific provisions/ chapters in trade agreements as well as the overall framework of trade liberalisation can accentuate this constraint (See Fig.1). Liberalisation of health related services coupled with investment liberalisation; the inclusion of IPRs at the WTO; and TRIPS plus provisions in IPR chapters in FTAs, 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. As FTAs are becoming more and more extensive (covering many areas) and more intensive (deeper liberalisation in existing areas) compared to the WTO, domestic policy space at the disposal of the Indian government to address gender inequalities and change the social structure can also be undermined.

Therefore, an analysis and evaluation of health impacts of India's trade policy on Indian women is necessary. Creating awareness on trade policy impacts, both in the trade agreements and in the domestic socio economic environment, is a good starting point. This brief is an attempt to provide information on such policy impacts in simple terms.

I. Women's Health Indicators in India

A look at socio economic and health indicators in India reveals the significant gender disparity. Women's socio economic achievement, in particular, remains a matter of concern in India, which despite efforts from several constituencies, 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).

Table 1: Inequality and Maternal & Child Health in India

	Poorest 20%	Richest 20%	Poorest 20% as Proportion of Richest 20%
Births Attended by Skilled Health Professionals (%)	16	84	0.19
One Year Olds Fully Immunised (%)	21	64	0.328
Children under Height for Age (% under age 5)	58	27	2.148
Infant Mortality Rate (per 1000 live births)	97	38	2.553
Under Five Mortality Rate (per 1000 live births)	141	46	3.065

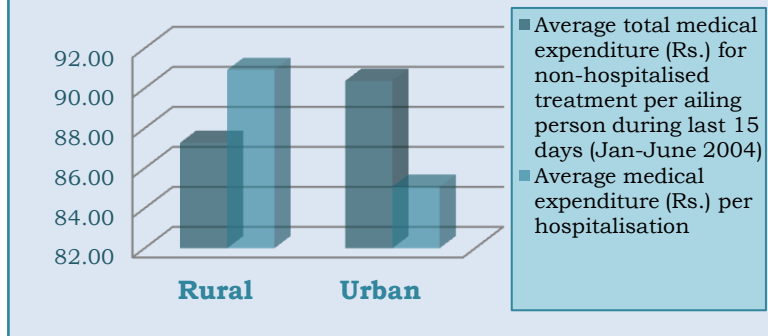
Source: Data Compiled and Calculated from UNHDR (2007/08)

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. Inequalities in income also have a direct impact on access to health services and maternal care (See Table 1). This also affects children's health indices. 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 are increasingly becoming victims of HIV/AIDS, a largely male dominated disease. Pressures of migration, violence against women, are related to this. Lack of information and denial of access to safe practices during sex are additional reasons for this situation. 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.

From a survey of health indicators of women in India, it is clear that location (rural/urban) has a significant role to play in its determination. Given the traditional structure of rural societies, the lack of general access to health facilities, coupled with a lack of education and employment opportunities, imposes severe restrictions on health improvement opportunities for women in rural areas.

Women's empowerment and health are clearly related but still has a long way to go. Only 27.1% of women in India seem to take decision about their own health care according to NFHS-3 (2005-06) while 30.1% of decisions are taken by the husband. While 62.2% of women take decision on their own or jointly with husband about their own health care, this seems to improve with education levels (NFHS 3). Only 60.3% of urban women and 41.5% of rural women are allowed to go alone to a health facility. This improves, apart from age, with education and employment status, especially with cash employment. This indicates the need for both economic and educational empowerment for improving basic access to health.

Fig. 2: Medical Expenditure on Females as % of Expenditure on Males (2004)



Source: Based on NSS Data (2004)

Gender discrimination is strong in accessing health services as well. Both hospitalisation and non hospitalisation expenses on women is always lower than that on men (see Fig.2, the % s are always <100), in both urban and rural areas. Surprisingly, discrimination vis-à-vis hospitalisation expenditure is higher in urban areas. Gender inequalities in health indicators are significant and seem to be strengthened by income, regional and social inequalities (social relations).

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 access to healthcare.

II. Trade Agreements, TRIPS Plus Provisions and Access to Medicines

Trade Related Intellectual Property Rights (TRIPS) is an associated WTO agreement that member countries signed up to in 1995. The TRIPS mechanism was set up to lay down minimum harmonised standards of protection of intellectual property, or the ownership of ideas, knowledge and technology, for the smooth conduct of free trade. Its primary purpose is to encourage innovation by giving the inventors rights over their creation. The short-run costs are to be offset by long-run gains for society in terms of knowledge and technology. The TRIPS Agreement relates to innovation as well as to the smooth transfer and dissemination of technology between inventor and users. It refers specifically to 'trade related' aspects of intellectual property.

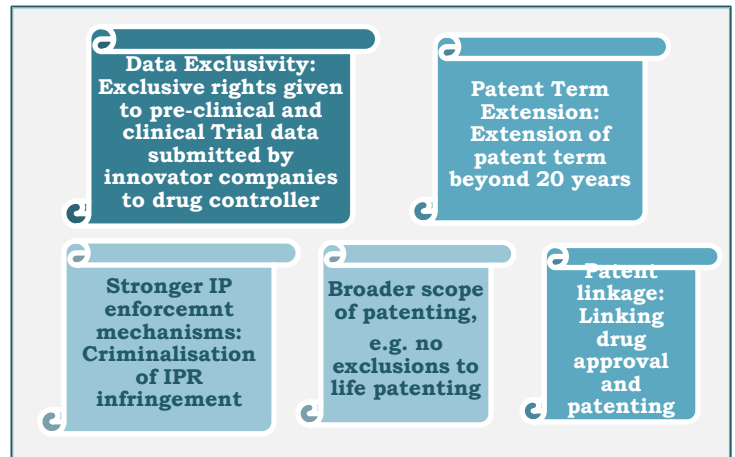
At the time the TRIPS Agreement was being negotiated no country in the world provided such long patent terms and many countries, including India, provided extremely limited IP rights in sensitive areas like food and pharmaceuticals. To comply with TRIPs, India amended its Patent Act of 1970 in 2005 and allowed both process and product patents in pharmaceuticals. This has triggered product patenting to a large extent with foreign multinational companies being primary players. The number of drug patents granted by the India patent office has gone up since 2005.

Women in India and in most of the developing world lag behind both in resource ownership (capital, land) as well as in educational attainments. On the other hand, they are often the most affected by the rise in prices and lack of availability of products, medicines and healthcare.

Starting with the TRIPS/WTO, the IP regime has become increasingly stronger under bilateral trade agreements. Many TRIPS plus conditions (See Fig. 3) are imposed especially by developed countries on their FTA partners. Even some of the flexibilities offered by TRIPS are taken away by TRIPS plus conditions in FTAs (*to know more about these flexibilities, see Part 3 (IPRs) of this series*). Restriction of pre grant opposition, data exclusivity or protection of trial data (parallel to IP), patent market linkage, patent term extension, constraints on compulsory licenses and parallel imports, ever-greening are some of the TRIPS

plus provisions are increasingly demanded by developed countries, such as the EU, with which India is negotiating FTAs. These are discussed in

Figure 3: TRIPS plus IP Provisions in Free Trade Agreements



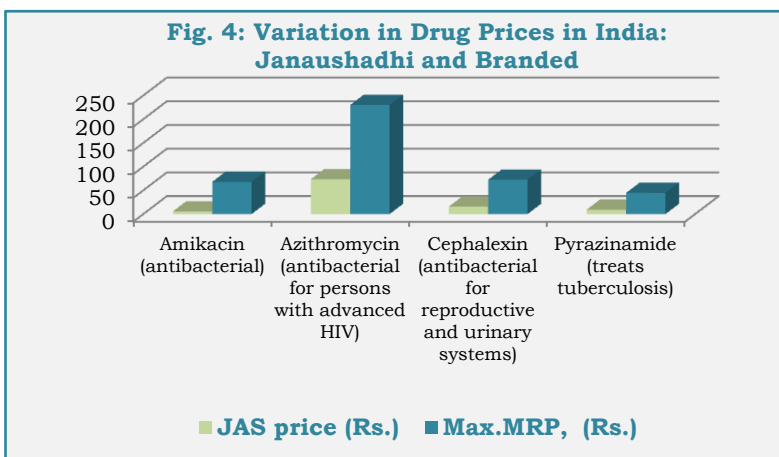
detail below. If India grants such conditions, it can severely impact access to critical medicines and treatment especially for those who already have unequal access.

Data exclusivity, or strict restrictions on public disclosure of trial data even before a patent is granted, has been a key demand of EU in its FTAs. This implies that national regulators cannot refer to trial data submitted by the original manufacturer to grant marketing rights to a generic producer for a certain period of time. So generic producers will now have to submit their own data and repeat clinical trials if they have to enter the market.

Not only is this costly and often unaffordable for small producers, it also encourages additional clinical trials, often on women and poor, increasing health risks. This is against the Helsinki declaration on medical research. The system provides a parallel protection to IP, and prevents generic producers from supplying, increases prices taking medicines out of reach of vulnerable groups like women.

Patent term extension to beyond the TRIPS'-stipulated 20 years and patent linkage (linkage of the patenting and marketing set ups) are other controversial inclusions in FTAs that impose further constraints on medicine supply and prices. In addition, 'border measures' which are a set of provisions that relate to IP enforcement are brought in several FTAs, for example in the European FTAs. This allows EU to confiscate

medicines which are going from India to another country. India has contested such confiscations in the past but is pressurised by EU to sign to such provisions in its FTA. This threatens the health of not only Indian citizens but of the vast majority in developing countries which receive supply of



Source: From Data provided in 'Comparative Analysis of Jan Aushadhi & Average Branded Market Price', Dept. of Pharmaceuticals, GOI

cheap generic medicines from India. Finally, limitations on the use of TRIPS flexibilities such as the use of compulsory licenses and parallel importation, if brought in by FTAs, will deny developing countries the right to protect public health and reduce supply of medicines its vulnerable.

In India, there is a sharp difference between the prices of drugs produced by branded companies and generic producers. 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 between that generic versions sold for example by Janaushadhi and branded varieties (see Fig.3). There is a large price variation even within branded drugs. Trastumazab, a key medicine for breast cancer has been patented in India and is available at the price of Rs. 124,000 per month per person. Therefore, cost of treatment for the required 52 weeks becomes prohibitive. Constraints on access to medicines are going to prove especially critical for HIV/AIDS treatment, a disease affecting an increasing number of Indian women.

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.

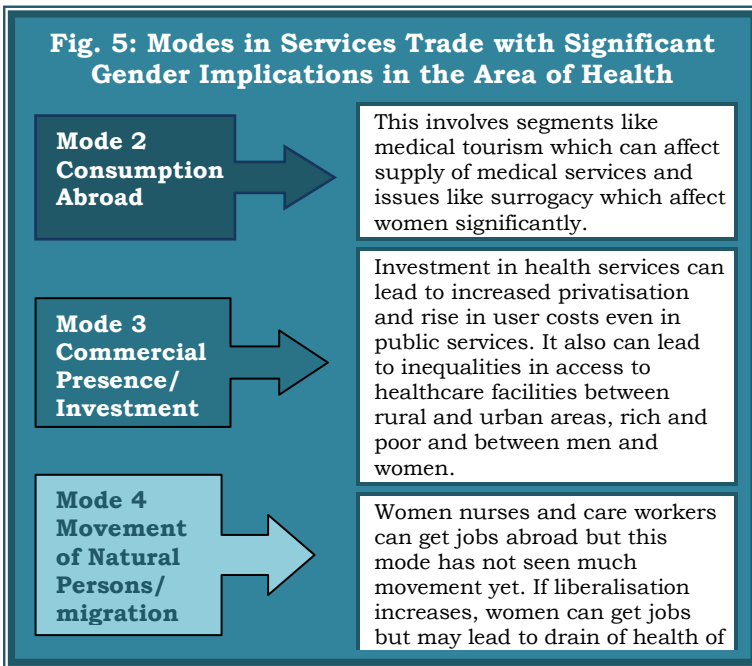
As argued before, any constraint on access to medicines acts as a stronger constraint on women. First, women are generally economically poorer than men, both across and within households. Second, in situations of constraint in access, it is most often the women who give up treatment either voluntarily or involuntarily. For example, in HIV/AIDS affected couples, the woman often gives up the medicine if supply is limited or expensive (Sengupta and Jena 2009). Third, as discussed, women in developing countries both practice and use traditional medicines extensively. The combination can seriously impact women's medicines access and health.

III. Trade and Investment in Health Related Services

Services liberalisation takes place under the four modes (See Part 2 of this series on Services). Mode 1 or cross border supply of services such as in IT has provided jobs and opportunities to Indian women workers and has improved scope for treatment through services like tele-medicine. However **Modes 2-4** have a more direct impact on gender dynamics in the field of health (See Fig.5). While the General Agreement on Trade in Services (GATS) is an associated WTO Agreement, it has seen very little opening up of the services sector across member countries, except in some services like hospital services. The FTAs, especially those in which developed countries are partners, target more opening up of the service sector.

India is opening up its service sector significantly under its FTAs, especially with developed countries and intends to follow up with service chapters even in those FTAs which are initially only about goods trade.

Fig. 5: Modes in Services Trade with Significant Gender Implications in the Area of Health



under medical tourism, is a much debated area where activists have asked for more regulation. If foreign investors from partner countries set up facilities supplying surrogate babies they will be entitled to these rights under FTAs. Future regulations in the sector, even if in the interest of the surrogate mother, may infringe on liberalisation combined under Mode 2 and Mode 3.

Mode 3 and Access to Health Services

On the other hand, foreign investment in foreign owned hospitals, for example, also provides undue competition to domestic and state run hospitals, drives up user prices and necessitates a switch from public to private expenditure on health (Sengupta and Sharma 2009) by chasing out public services. It increases private facilities at the cost of public ones with cost to the poor.

Mode 2 and Medical Tourism

In the field of health, this mode relates to issues like medical tourism. India has been trying to encourage medical tourism and is by now well known for acting as a major destination for providing high quality medical services at cheaper rates compared to the developed countries. Mode 2 has already started posing certain problems. First, it takes critical facilities away from domestic needs. Second, it exerts an upward pressure on costs of healthcare and therefore on government budgets if government hospitals have to stay competitive. Otherwise, user fees in government facilities must go up. This has been pointed out by the National Commission on Macro Economics and Health (NCMH) (GOI 2006). Women, especially poor women, are likely to be a disproportionate sufferer because of shrinkage of access.

But under FTAs, in combination with Mode 3 or investment liberalisation, 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. Under FTAs, investors’ rights are very strong and national governments cannot pass laws in future that can infringe upon investors’ rights, property or foreseen profits. Surrogacy, an area thriving

Increased privatisation has already skewed access against the poor, especially in rural areas. This is not surprising as data shows that expenditure per case in private hospitals is 2-3 times higher compared to public hospitals (see Table 2). But most Indians are forced to avail private services as of total current health expenditure in India, only 25 per cent is public expenditure (WHO Statistics 2009). As Fig.6 shows, the disparity between private and public healthcare is much higher for

Table 2 : Average Medical Expenditure (Rs.) Per Hospitalisation Case in India

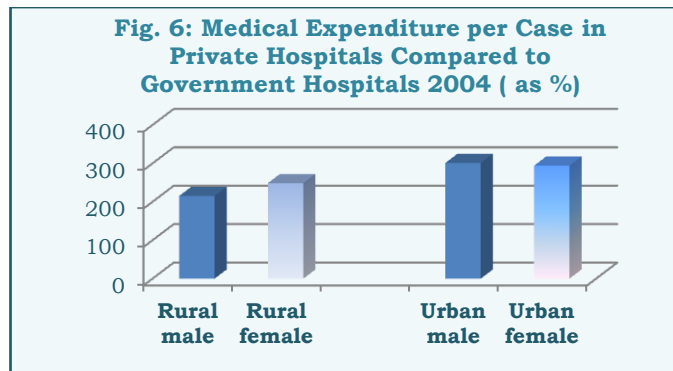
Type of Hospital	Rural		Urban	
	2004	1995-96	2004	1995-96
Government Hospitals	3238	2080	3877	2195
Private Hospitals	7408	4300	11553	5344
Any Hospital	5695	3202	8851	3921
Expenditure in private hospital as a % of that in govt. hospital	228.78	206.73	297.99	243.46

Source: NSS (2004)

women compared to men in rural areas. This may have a significant impact on deterring rural females from getting treatment in private hospitals.

Until now India has received only Rs 29687 million (April 2000-July 2009) or 0.715 per cent of total FDI received by India in spite of allowing

100 per cent FDI through the autonomous route. But the Indian health sector is growing and the availability of skilled health professionals makes this an attractive business opportunity for foreign investors. This also offers opportunities for linked services like medical tourism.



Source: Based on NSS Data 2004

But what India needs is public services at low cost, not private services at high cost which replaces public services. In addition, like in banking, FDI has traditionally chosen 'safe' areas as its destination. Out of the 62 cases of foreign investment in hospitals or diagnostic centres approved between 1991 and May 2001, most have been concentrated in cities and in large metropolises like Delhi, Kolkata and Chennai (Gopakumar 2009) where medical services are already well developed.

Mode 4 and the Movement of Women Workers

This is a critical issue from a gender perspective as the number of women migrant workers from South Asian countries, including from India, is significant. However, liberalisation under Mode 4 has made little progress under GATS. It has remained limited to temporary movement of workers, and is often linked with 'commercial presence' of companies. It is also mostly limited to 'professional' or skilled workers, and women domestic workers are at best semi skilled. Therefore, Mode 4 involves a very narrow definition of migration. Strict entry barriers exist in most countries, especially in developed countries, in the form of entry tests, language test, pre employment, confinement to sectors and locations, and absence of wage parity (Sengupta and Gopinath 2009). Both developed and developing countries have significant barriers, though developed countries, for example the US and the EU, are seen to have much stricter entry norms.

Liberalisation of Mode 4 under GATS therefore has not been of much use to India's women workers, e.g. nurses. The critical need of India's migrant unskilled female care workers still continue to be out of bounds for Mode 4.

India sees gains in Mode 4 as a critical element of its FTAs and uses this to justify its FTAs to its citizens. However, the limitations on Mode 4 imposed under GATS, seems to continue under most FTAs. India is largely concentrating on getting more benefits for its IT and other professionals. Under the agreement with Japan, India has got some additional benefits for contractual workers who are not attached to specific companies. In both the agreements with Japan and Malaysia, signed in 2011, India is hoping to get access for nurses and care workers in two more years. This may give some benefits to women caregivers, but significant barriers still remain. In Japan, language is a critical barrier for Indian workers. In addition, Mode 4 workers do not yet get protection and rights similar to the citizens in these countries and cannot access the domestic law in these countries. Most developed countries are still very cautious about allowing migrant workers and real gains in this segment may be much more difficult to achieve.

However, from a development perspective, this may be a blessing in disguise for India as outmigration of health and care workers also tends to produce a drain and threaten health care within India.

IV. Direct Health Impact on Women Workers in Export Based Industries

An increasing concern with trade liberalisation is the direct impacts on health of workers in export based industries. This is clearly linked to trade liberalisation which generates a framework of intense competition. Under FTAs, with border duties being totally removed, the competition increases further.

The pressure of retaining the competitive edge is passed on to the labour force by using various tools. The use of female workers, who are unorganised and relatively pliant, on a casual basis gives the opportunity to pay lower wages, impose adverse work conditions, give inadequate medical benefits including on maternity. They can also be fired as and when needed to adjust to the volatile demand of international trade.

While women have got a large number of jobs in export based industries such as garments and agro based exports including tobacco, the harsh working conditions have already created adverse impact on their health. Since women dominate these sectors in many of the Asian economies, including in India, this is a matter of serious gender concern. This phenomenon has been documented across Asian countries (See Sengupta and Gopinath, 2009).

Many developed countries, led by the EU, ask developing countries to include labour standards under a chapter on ‘sustainable development’ in their FTAs. However India rejects such chapters on what it sees as non-trade issues and argues that these as non-tariff barriers. This represents one of the most contentious areas in India’s ongoing trade negotiations with the EU. It is true that tackling labour standards is complicated in a bilateral forum and will reduce India’s advantage if other countries in similar situations do not comply. But India does need to take its labour standards, and the health and safety of its workers seriously.

V. IPRs, Agriculture, Food and Health of Women

The TRIPS plus provisions in FTAs affect not only the access to medicines but access to food as well. Under the EU-India FTA being currently negotiated, the EU is likely to ask India to join the UPOV 1991 convention. This Convention recognises the seed breeders’ rights as opposed to farmer’s rights. There are other issues as well. The use of GMO seeds, often pushed by FTAs, for example, is not only fraught with health and safety concerns, but also have to be bought each season. Both UPOV 1991 and GMO seeds reduce the farmers’ ability to freely exchange and reuse seeds. These also reduce 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 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 on their nutrition and health.

VI. Constraints on Domestic Policy Space

Finally, the increasing constraints on domestic policy space to regulate and intervene in the health system, especially to protect vulnerable groups, is a matter of increasing concern. This is a cross cutting issue and is particularly visible in both goods and goods-plus chapters in FTAs (see Box 1). For example, government policy space to regulate domestic health conditions may be affected by the TRIPS plus provisions in FTAs and its constraints on compulsory licensing, parallel importing etc. The establishment of competition policy and full liberalisation of public procurement by removing preferential treatment of small producers/ MSMEs can affect national governments’ ability to address inequities in health care and ensure the availability of medicines and treatment.

Box 1: Some Issues under FTAs Affecting Domestic Policy

- ☞ Removal of tariffs fully reduces government revenue that could have been spent on health and in addressing health inequalities.
- ☞ TRIPS plus IPRs such as limits on using compulsory licensing and parallel imports affect supply and prices of medicines
- ☞ Investors’ rights under FTAs can prevent future regulations and enactment of laws in the interest of public health as well as women’s health.
- ☞ Public Procurement liberalisation may lead to the elimination of cheaper producers and to higher costs of medicines.

With the increasing number of FTAs, these constraints start dictating both the nature and pace of domestic policy reforms. Such constraints are already visible in the domestic policy arena. For example, the Central and many state governments have recently raised the turnover limit of pharma companies that can bid for public purchase contracts to Rs. 25 crores, thus already eliminating many smaller producers.

VII. Conclusion

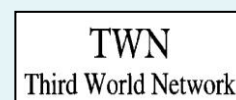
India is engaging in an increasing number of bilateral trade agreements (FTAs). Apart from WTO commitments, the provisions in several chapters/areas under FTAs can impact women's health. The direct impact on women's health as well as on the access to medicines and treatment create a combined impact on women's health. When these are superimposed on the traditional structure of gender disparities in India, the adverse impact on women's health can become manifold. The current trade framework is often based on the exploitation of the weakest while making the strong stronger. Women are already facing severe disparity, both in employment and incomes as well as in access to healthcare, and are now made to bear a disproportionate burden. *Even if* increased foreign investment in health services

under trade agreements bring in extra facilities, these are often costly and are located in urban areas. This limits the usefulness of such investment for easing treatment constraints in rural areas and for vulnerable groups. Moreover, the government is losing policy space to address health related inequalities and impacts.

Given this increasing impact of trade and investment on such an important social and human indicator, it is important to evaluate trade agreements from a development perspective. For that to happen, understanding these linkages is a must not only among policy makers, parliamentarians, academics and technical analysts but among larger civil society as well. Women themselves must analyse these issues and create pressure groups so that a field of major policy making in India does not leave their welfare behind.

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