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COMMENTARY

Policy coherence and conflict of interest: The OECD guidelines on health and poverty

TIM ANDERSON

Political Economy, University of Sydney, Australia

Abstract
The OECD's Guidelines on Poverty and Health are compromised by neoliberal assumptions and corrupted by several major conflicts of interest. These conflicts of interest are embodied in the DAC guidelines, whereby specific OECD commercial interests influence the public policies of developing countries. Commercial agendas are being incorporated into developing country health policy through development assistance doctrine. Yet better critical health outcomes generally occur in the well-coordinated, public health systems, rather than those with high levels of private supplementation. This paper examines the OECD Guidelines' construction of public health policy in poor countries, drawing attention to the ideological agenda and linked conflicts of interest.

Keywords: *Poverty and health, OECD, conflict of interest*

Introduction

The OECD's 'pro-poor health approach' and its DAC Guidelines on Poverty and Health (2003) are deeply compromised by neoliberal assumptions and corrupted by several major conflicts of interest. These conflicts of interest form a 'Trojan horse' in the DAC guidelines, whereby OECD country commercial claims in the areas of infrastructure investment, intellectual property and other profitable services are ported into the public policy of developing countries. Based on the asserted top priority of resource supplementation, commercial agendas—resisted by developing countries at the WTO—are being incorporated into developing health policy through development assistance doctrine.

This paper reviews the health policy debate over aid for developing countries, using an international comparative study of critical health outcomes, combined with interest analysis, to disentangle 'technical assistance' from vested interest agendas.

I will first look at some apparently consensual principles noted by the OECD (2003), pointing out the compromised elements. Second, I will look at a central polemic—that

Correspondence: Dr Tim Anderson, Political Economy, University of Sydney, PO Box 109, Glebe, NSW 2037, Australia. E-mail: tima@econ.usyd.edu.au

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healthcare in developing countries is principally a question of resource deficiency and that, therefore, supplementation by outside agencies and private investors is the central requirement. Third, I will look at some specific conflicts of interest that emerge from the covert privatization agendas of the OECD health and poverty guidelines.

Compromised leading principles

The OECD 'guidelines' report (2003) leads with a number of apparently non-contentious principles, concerning health promotion in developing countries. Certainly the monitoring of disease and health indicators, better education, the use of decentralized health programs that encourage civil participation, and the integration of health policy with water, nutrition and education programs (OECD, 2003, pp. 16–17) are all well supported by experience and evidence. Public health is clearly not just about health services.

However, the linking of health policy to 'pro-poor' strategies, often administered by the multilateral banks ('poverty reduction strategies', prior to 1999 called 'structural adjustment programs'), and the demand for a 'scaling up' of resources through private-sector partnerships ('pluralism' of services), immediately begins to compromise these leading principles, in particular the coordination and access regimes of health services. The supposed logic of markets and the interests of global investors muddy the OECD's claims to represent the health interests of poor people. Conflicts of interest have been entrenched, in particular, through the language of 'health and trade policy coherence' (WTO & WHO, 2002). The OECD approach for developing countries could be compared with a public health approach (see Table I), which remains the dominant paradigm within most of the OECD countries themselves.

Because the World Bank-enforced demand to open new fields for private foreign investors is at the heart of every 'poverty reduction strategy' (embedded as this demand is in Article One of the World Bank's charter), the *means* towards this form of 'poverty reduction', 'pro poor health system', 'institutional strengthening' and the reshaping of 'global public goods' (OECD, 2003) is invariably one that facilitates entry of private for-profit investment, usually in the name of 'broad-based growth'. Whether the objective is economic growth, health promotion 'or poverty reduction', the *means* remains much the same. The conditional requirements of international financial institutions (such as the World Bank) and the epistemic communities created through neoliberal ideology

Table I. OECD DAC health principles: Consensus and contention.

OECD DAC (and IFI) model	Public health approach
Monitoring, epidemiological vigilance	
Education in health and hygiene	
Decentralized and participatory health programs	
Integration of health policy with infrastructure, nutrition, water and sanitation	
Resource supplementation of services through private investment ('pluralism')	Public investment and coordination
Private participation (privatization) of water and sanitation	Guaranteed access to essential hygiene-linked services
Private insurance and user pays regimes	Guaranteed universal access service regime

maintains these consistent means (Madrid, 2003; Mehrotra, 2004), in part by use of the 'coherence' arguments.

In the 1990s 'structural adjustment programs' (SAPs, the predecessor to the post-1999 'poverty reduction strategies') were roundly criticized for damaging a wide range of rights, including the right to health. The UN's Special Rapporteur on Discrimination Against Minorities, Mr Danilo Turk, found that SAPs jeopardized the rights to work, to food, to housing, to health, to education and to development (Turk, 1992). The burden of structural adjustment in Africa had fallen on those dependent on domestic investment and government services (Turk, 1992).

One large NGO monitoring group looked at structural adjustment across many countries and found that the privatization processes encouraged by SAPs had contributed to an increase in unemployment and job insecurity, had weakened workers' rights and had increased service costs while reducing service quality. In some cases privatized services had become more inefficient than public enterprises. Similarly, policies of capital and trade liberalization had weakened agricultural sectors, had impacted negatively on women and unskilled workers and had aggravated inequalities. Public expenditure cuts and increased user fees had damaged access to healthcare, education and housing for poor and disadvantaged groups (SAPRIN, 2000).

The 1999 re-badging of World Bank/IMF structural adjustment programs as 'poverty reduction' or 'good governance' programs suggests some change and Ruger (2005), a former World Bank employee, suggests that World Bank participation in health programs has indeed increased and changed focus. Independent observers have noted the great continuities between 'structural adjustment' and 'poverty reduction' programs (GAO, 2001; WDM, 2001), including the continued push for privatization of social services (Mehrotra, 2004; Mehrotra & Delamonica, 2005). The Word Bank itself has recently stressed a commitment to 'equity' in development, but 'equity' is defined (in neoliberal terms) as equality of opportunity and 'not equality in outcomes', allowing the bank to sustain its emphasis on market mechanisms and rapid economic growth (World Bank, 2005, pp. 2–17). The OECD DAC principles on poverty and health, with their stress on private resource supplementation, private infrastructure development and market mechanisms (including private insurance and user-pays services), are broadly coherent with both the older and the newer World Bank views on financing health services and neoliberal 'equity' (World Bank, 1987, 2005).

With the global trend for gradually increasing life expectancy (an average 10% increase between the early 1970s and the late 1990s), it is disturbing to note that a number of countries under long-term SAPs (e.g. Zambia, Zimbabwe, Uganda, Botswana, Mozambique, Russia, Ukraine) have actually had falling life expectancy, between the 1970s and the 1990s (UNDP, 2004). Long-term 'structural adjustment' has aggravated these appalling trends. Such is the danger of linking neoliberal 'Poverty Reduction Strategies' to health reforms. This is the first compromise of the OECD's health and poverty guidelines: a doctrinaire 'market' approach to 'poverty reduction' is also strongly linked to public health policy.

Private supplementation versus social organization

The central argument in OECD and World Bank plans for developing-country health systems focuses on an expansion of resources, by private-investor supplementation, and at the expense of social organization, that is, coordination, training and universal access.

The polemic is really between 'private supplementation' and social organization, rather than simply public versus private investment because, as many studies show (e.g. Wagstaff, 2002), in poorly organized systems, patterns of public health investment also disadvantage poor people.

The OECD pushes for 'scaling up resources and private investment', with the guideline report stating that 'scaling up financial resources for health should be a priority' (OECD, 2003, p. 14). This is consistent with the study commissioned by the World Health Organization on 'Macroeconomics and Health', and chaired by Jeffrey Sachs. This report pushed for a massive expansion of foreign capital in poor country health systems:

> The level of health spending in the low income countries is insufficient to address the health challenges they face... poor countries can increase their domestic resources that they mobilize for the health sector and use those resources more efficiently... donor finance will be needed to close the financing gap... [this will mean] approximately $27 billion per year in donor grants by 2007. (Sachs, 2001, p. 16)

'Donor finance' here can be read in the normal 'development assistance' context—a core of public 'seed' money that may be grants or loans, which then sets the conditions for entry of a consortium of private, commercial capital. In this way, developing-country health systems may become fields for private and foreign investment in infrastructure and service provision.

Apart from stressing the expansion of health resources through private supplementation (also called 'partnerships' and 'participations'), the OECD line is hostile to the coordinated and assured access elements of social organization. An earlier OECD view of the Mexican health system criticized the 'public integrated model' that existed in the national hospital system, calling it a 'quasi-monopoly' and a 'command and control' system which provided 'no effective consumer choice' (OECD, 1998, pp. 100–102). Yet consumer choice is hardly the major issue in the fragmented Mexican system, which fails to provide effective health coverage to at least 45% of the population that is not enrolled in any of the compulsory social security schemes (Carpizo, 2003; PAHO, 2002). Moreover, the attempt to apply a 'command and control' label to a public integrated health system is inappropriate. Such expressions have also been used by World Bank officials when rejecting finance for the development of other important public institutions in developing countries (e.g. World Bank, 2000). Historically, 'command and control' was a reference to Stalinist planning in the old Soviet Union. In the context of discussions over public health systems in developing countries it represents a doctrinaire and intemperate attack on decent institution-building processes.

The OECD 'pro poor' approach has thus disavowed public integration and stressed contributory, competitive and private investment processes. While looking at Mexico's health system, the OECD recognized major problems of access to services, the existence of a 'segmented system' with poor coordination, inequities, inefficiencies, deficiencies in infrastructure and the need to 'reduce disparities in health status' (OECD, 1998, pp. 88, 91–97). However, in response to this dilemma, the OECD backed a proposed massive expansion of health insurance through voluntary affiliation, family insurance packages and the decentralization not only of health programs but of financial responsibilities (OECD, 1998). Such a process failed, in the following few years, to lift health insurance rates more than a fraction (PAHO, 2002, 2003). It also does not seem to be addressing the serious regional and country-wise disparities in health outcomes (Lozano et al., 2000; see also Secretaria de Salud, 2001).

Private supplementation and the market-access argument of 'competitive service provision', in the name of an expansion of health resources—without proper coordination,

assured health service access and the appropriate training of a body of health professionals—is a virtual guarantee for wastage, inefficiency, limited access and poor health outcomes. Twenty years ago Barros, Vaughan and Victoria (1986) noted the 'clearly' increased use of expensive caesarian sections in Brazil, amongst low-risk expectant mothers who nevertheless had private health insurance. However, the weakness of the 'resource supplementation' argument is most obviously seen in the general health performance of the USA, which, is both a highly privatized system and spends far more on health per capita than any other country. For all this investment, US basic indicators remain relatively poor.

We can usefully compare the efficacy of the US health system with those of the top 10 ranked countries in the UNDP's Human Development Index (Table II). The HDI is based on income but tempers this with life expectancy and some basic education measures. Putting aggregate health inputs against some key health outcomes we can see that the US has a far greater resource input but below average health outcomes. At 13.9% of GDP, US health expenditure is far above that of any other country. The next biggest spender is Germany, at 10.7%—just 77% of the US figure (Reinhardt, Hussey, & Anderson, 2004). Not only are US infant and maternal mortality outcomes below average, they are the worst of these top 10 countries. In fact, we have to descend to Number 29 on the HDI (Barbados) to find an infant mortality figure worse than that of the US; and we find the same infant mortality figure as far down as Number 52 (Cuba) (UNDP, 2004, see Table 9). In fact, Cuba has since surpassed the US on this critical indicator (interview with Dr José Portilla, Havana, 27 May 2004—Dr Portilla is an official with the External Relations branch of the Ministry of Public Health).

If overall resources devoted to health are therefore no good measure of either superior aggregate health outcomes, or of efficiency in a health system, what about the extent of private supplementation? There is no reason not to continue the comparison of wealthy countries, to draw lessons for developing countries. But let us move away from the US to look at a range of OECD countries: those where the proportion of private expenditure was 40% or more in both 1990 and 2000; and those where the proportion of public expenditure was 80% or more between 1980 and 2000. Infant mortality is once again a useful indicator (Table III). It is fairly reliable, and its measure to a fair degree defines the difference in health outcomes between advanced and developing countries.

Although proportions of public and private expenditure are by no means definitive of health outcomes in themselves, they demonstrate that those OECD member states with high public expenditure on health (consistently more than 80%) perform better in containing infant mortality than those that rely on mixed public–private systems (consistently more than 40% private). Every single OECD country that had a high proportion of public expenditure on health had at least 10% better than OECD average

Table II. US health expenditure and mortality outcomes.

	Health expenditure, 2001		Mortality	
	US$PPP per capita	as% of GDP	Infant, 2002	Maternal, 2000
USA	4887	13.9	7	17
Average of top 10 HDI countries	2720	9.1	4.7	9

Source: UNDP (2004); OECD (2002) in Reinhardt et al. (2004).

infant mortality figures, in each of the four years marking the start of a new decade (1970–2000). The average rate for this group of six maintained a high level of 30–45% better than the OECD average (OECD, 2003). Two more important factors—the extent of public guaranteed health service access, and health worker intensity—appear to reinforce this trend.

By contrast, of another six OECD countries that consistently had at least 40% of private health expenditure, infant mortality rates were poorer. Despite some substantial improvements, only one of these 'privatized six' countries (Switzerland) at times (1980 and 1990) reached the average infant mortality rate of the 'public six'. The better performing 'privatized' systems (Switzerland and Greece, then Korea) all had 100% publicly guaranteed access to health services and a relatively high intensity of health workers. OECD best practice therefore clearly suggests that relatively high rates of public expenditure, combined with high rates of health professionals, will lead to better health outcomes in infant mortality (OECD, 2003). These organizational factors appear to be better indicators of critical health outcomes than gross resource input.

The public–private question is even more serious in developing countries, because socioeconomic inequalities compound into serious health problems so rapidly. Marginalization and exclusion can be devastating. Mexico is a fine example of this. Looking at the best and worst state indicators (the worst states were usually Chiapas, Oaxaca, Guerrero, or Mexico state), access to clean water differentials was up to 11 times, mortality by malnutrition five times, diarrheal illness more than eight times, and mortality by tuberculosis more than seven times (Secretaria de Salud, 2001). County-based studies have shown some even higher differentials. In one comparison between a wealthy county

Table III. Infant mortality in countries with more or less public spending and more or fewer health workers, OECD comparisons.

	1970	1980	1990	2000	High HW ratio? (3)	Public coverage?
OECD average	26.3	16.7	10.3	6.5		
High public expenditure countries (1) (4)						
Denmark	14.2	8.4	7.5	5.3	Y,Y	100
Iceland	13.2	7.7	5.9	3	Y,Y	100
New Zealand	16.7	13	8.4	5.8	N,Y	100
Sweden	11	6.9	6	3.4	N,Y	100
Norway	12.7	8.1	7	3.8	N,Y	100
United Kingdom	18.5	12.1	7.9	5.6	N,Y	100
Average of above six	14.4	9.4	7.1	4.5		
Percentage better than OECD average	45	43	31	31		
High private insurance countries (2)						
Greece	29.6	17.9	9.7	6.1	Y,N	100
Korea	45	17	12	6.2	N,N	100
Mexico	79.3	50.9	36.1	23.3	N,N	45–55
Switzerland	15.1	9.1	6.8	4.9	Y,Y	100
Turkey	145	117.5	57.6	39.7	N,N	66
United States of America	20	12.6	9.2	6.9	N,N	25
Average of above six	55.7	37.5	21.9	14.5		
Percentage better than OECD average	−112	−124	−112	−123		

Notes: (1) Countries with at least 80% public funding of health expenditure between 1980 and 2000; (2) countries with at least 40% private expenditure on health in both 1990 and 2000; (3) high health worker ratio = sustained high rate of doctors and nurses (D,N) per population—at or above OECD average rate for each of 1970, 1980, 1990 and 2000; (4) public system coverage is for 2000; (5) recent Eastern European OECD members were excluded. Source: OECD (2003) *OECD Health Data*, 2nd ed.; OECD (2003) *Health at a Glance: OECD Indicators* 2003 (Paris, Organization for Economic Cooperation and Development).

and a marginalized county in two different states, Mexican researchers found the well-off county had 25 times the per capita expenditure on health, 20 times the improved water sources, twice the sewage facilities, far fewer hospital births and three times the literacy rate. The impact of such unequal resourcing on health outcomes was through substantially higher diarrheal diseases, nutrition deficiencies and tuberculosis, and significantly higher respiratory infections and perinatal problems (Lozano et al., 2000).

Looking at the public–private split in the more successful developing nations we can see, once again, that high levels of private supplementation tend to correlate more closely with *poorer* health outcomes. In Table IV I have looked at middle-income developing countries (those with an HDI ranking of 50 or above) and selected the top seven of those (in HDI terms) that have less than 25% of their expenditure as private expenditure, and the top seven of those (in HDI terms) that have more than 50% of their expenditure as private expenditure. I have then listed key mortality outcomes within these health systems.

Both the average and the median infant and maternal mortality figures for the highly privatized group are significantly worse than that for the more public group (see Table III). Furthermore, the privatized group spent substantially more resources per capita on their health systems than the public group—indicating a less efficient deployment of resources. The privatized group also had, on average, significantly fewer trained doctors per head of population, despite this extra expenditure. The higher doctor per population ratio may be one reason for the superior performance in the more public group. Other likely reasons are that the more privatized health systems are more fragmented and less coordinated, and that universal access to health services is seriously compromised by being tied to private insurance subscription or fee-for-service regimes, or both.

The privatized group also represents generally far more unequal societies, in terms of income, and this most probably links in turn to differential access to quality housing, water and sanitation. It should not be surprising that unequal societies have worse health outcomes. Recent studies have shown that health is strongly and consistently correlated to income and socioeconomic status, independent of access to healthcare; and that there are strong correlations between income inequality and levels of trust, participation and social investment (Daniels, Kennedy, & Karachi, 1999). Health inequalities in turn are almost always to the disadvantage of the poor (Wagstaff, 2002), while income inequality typically impacts on public resource deployment not only in health but also in schools, social welfare and workplace conditions. Equalizing such strategic investments has been said to be 'likely to have the most impact on reducing health inequalities and improving public health' in both rich and poor countries (Lynch, Davey Smith, Kaplan, & House, 2000, p. 1203).

None of this is extraordinary or difficult to determine. Yet it is information often ignored, precisely because of commercial conflicts of interest and investment agendas. Advocates of private supplementation in the OECD and the World Bank were well aware of the relative importance of societal and organizational factors over gross resources, because they funded a study that demonstrated this, which was published in the 1999 annual report of the WHO.

This study for the WHO, across 115 (mostly developing) countries, showed that there were two more important factors than income (and therefore than economic growth) in making gains in mortality reduction (Table V). The education of women and the generation or adoption of appropriate technology were each significantly more strongly correlated to reductions in mortality than increases in income (Wang et al., 1999).

Table IV. Developing countries—health expenditure and mortality outcomes.

	Health exp per capita PPP US$, 2001	Gini index, *c.* 2000	Public health exp,% GDP 2001	Private health exp,% GDP 2001	Doctors per 100,000, 1990–2003	Infant mortality, 2002	Maternal mortality, 2000
Top seven developing countries (HDI = 50+) with <25% private health expenditure							
Cuba	229	32	6.2	1	596	7	33
Bulgaria	303	32	3.9	0.9	344	14	32
Macedonia	331	28.2	5.8	1	219	22	23
Belarus	464	30.4	4.8	0.7	450	17	35
Romania	460	30.3	5.2	1.4	189	19	49
Oman	343	na	2.4	0.6	137	11	87
Samoa	199	na	4.7	1	34	20	130
Average	333	30.6	4.7	0.95	281	15.7	55.6
Median	331	30.4	4.8	1	219	17	35
Top seven developing countries (HDI = 5-+) with >50% private health expenditure							
Mexico	544	54.6	2.7	3.4	156	24	83
Trinidad and Tobago	388	40.3	1.7	2.2	75	17	160
Bosnia and Herzegovina	268	26.2	2.8	4.8	145	15	31
Brazil	573	59.1	3.2	4.4	206	30	260
Jamaica	253	37.9	2.9	4	85	17	87
Lebanon	673	na	3.4	8.8	274	28	150
Armenia	273	37.9	3.2	4.6	287	30	55
Average	425	42.7	2.8	4.6	175	23	118
Median	388	39.1	2.9	4.4	156	24	87

Source: UNDP (2004, Tables 6, 9, 14).

Table V. Sources of mortality reduction, 1960–1990.

	Percentage contribution of gains in		
	Income	Education of adult females	Generation/utilization of new knowledge
Under-five mortality rate	17	38	45
Female adult mortality rate	20	41	39
Male adult mortality rate	25	27	49
Female life expectancy at birth	19	32	49
Male life expectancy at birth	20	30	50
Total fertility rate	12	58	29

Source: Wang et al. (1999).

The development banks see this research but then revert to their focus on 'broad-based growth'.

It is clear that the social organization and coordination of health systems is significantly more important than the level of finance, in both wealthy and developing countries. In particular is the coordination that is more likely to come from well-coordinated public systems in which there is guaranteed access of the whole population to health services, and the training of large numbers of well-qualified health workers. Yet each of these critical social factors can be undermined by the privatization agendas buried in the OECD's 'poverty and health' guidelines, as well as in the World Bank's 'poverty reduction' programs.

Conflicts of interest

The OECD guidelines skillfully combine public health concerns with the quite specific commercial interests of its predominantly US and European members. Motivated by its own investor interests, and drawing on the misleading 'resource supplementation' argument, the OECD urges the inclusion of several covert forms of privatization in developing countries' health systems.

These agendas are no doubt encouraged by bodies such as the OECD's Business and Industry Advisory Committee (BIAC). This is a powerful and active lobby which has effectively argued that health policy frameworks must be 'based on competition', because of supposed resource allocation (i.e. efficiency) benefits, and that healthcare systems should also be seen as a 'source of economic growth' (through private investment) rather than a 'burden' on public finance (BIAC, 2004, p. 2). Yet corporate investment agendas are to do with profitable opportunities, not public health. It seems trite, but it is necessary, to say that there may be conflicts of interest between these two objectives.

Three commercial agendas are spelt out in the OECD guidelines: (1) the push for large construction and service contracts in water and sanitation, (2) the expansion of patent monopolies, and (3) the opening of health services to private contractors and franchises.

First, the call for 'clearer recognition of the potential role of the private sector' in water and sanitation services (OECD, 2003, p. 60) flags a largely European interest. The EU Water Initiative in particular aims to 'reinforce political commitment to action and raise the profile of water and sanitation with a view to poverty reduction'. The way it proposes to do this is by creating 'stronger partnerships between the public and private sectors and local stakeholders' (Barth, 2003). These are mostly plans for privatized contracts in water

and sanitation, a global industry that is two-thirds controlled by two EU-based giant companies, Suez and Vivendi (now Veolia), but also RWE-Thames and SAUR (Wesselius, 2003). There are huge implicit problems of access and high monopoly prices in these privatization plans. Drawing on Millennium Development Goals (MDGs) and World Summit for Sustainable Development targets—for higher levels of access to drinking water and sanitation in developing countries—the EU Water Initiative promotes its notion of 'public–private partnerships' as the principal means to achieve these goals. The health guideline claim mirrors this EU initiative, as also do the EU's requests, in the WTO's GATS negotiations, for many developing countries to make a binding commitment to market access and national treatment in water services (Wesselius, 2003). However, this process is not about public access to water and sanitation but rather corporate market access; and it is most likely that public access will be damaged.

In Ghana, for example, water tariffs nearly doubled in anticipation of a large privatization scheme, backed by the World Bank. The Bank's US$103 million soft loan was to facilitate 'public–private partnerships' supposedly aimed at reliability of supply and expanding access (World Bank, 2004). In fact, the World Bank had mandated the 95% water rate hike to make the tender process more attractive to the likes of Suez and Vivendi, and the 'cream' market of Ghana's capital city Accra is the main focus of the contract (Public Citizen, 2004).

Second, there is the OECD call for recognition of the 'TRIPS compulsory licensing rules . . . to protect public health and nutrition' (OECD, 2003, p. 86). In fact this is a claim to legitimize a regime of patent fees for the big drug and biotechnology companies. The recent TRIPS exclusion rules (which proscribe highly restrictive circumstances under which drug patents can be avoided by 'compulsory licensing' and the production of generics) only came after worldwide scandals over massive prices being charged for antiretrovirals for HIV/AIDS. Yet the principal aim of the new rules is to protect monopoly rights, not public health.

Expensive patented medicines represent one of the major barriers to accessible healthcare in poor countries today. For example, price barriers and the consequent use of older and ineffective drugs comprise a major factor in the many thousands of malaria deaths in Africa today (WHO, 2003). Further, the 'rents' imposed through patent protection are never linked directly to the costs of developing new medicines, but rather to a standardized rule of thumb that guarantees 20 years' monopoly patent rights.

The Doha agreements on compulsory licensing are highly restrictive, and have not overcome the threat of substantially more expensive essential drugs, after 2005. Former Argentine IPR negotiator at GATT and the WIPO, Dr Carlos Correa, said that there are 'substantial' costs to developing countries from the full implementation of TRIPS, including 'price increases and [decreases in] the room left for national production' (Correa, 1998). Médicins sans Frontières (2003) says that the Doha provisional agreement:

> . . . would make generic production much less feasible after 2005, when key manufacturing countries [e.g. India] must fully implement TRIPS . . . the supply of affordable versions of new medicines would slow to a trickle, with developing countries having few alternatives to the high prices and long term monopolies of originator companies. (MSF, 2003, p. 2)

The Doha understandings on compulsory licensing (1) applied only to a list of diseases with little public health rationale (many with no drug treatment or off-patent drug treatment); (2) eligible importing countries would have excluded some large countries (and large markets) like Brazil, South Africa and the Philippines; and (3) would restrict such licenses to 'emergency situations' only (MSF, 2003, p. 3). So the OECD's claim

that TRIPS compulsory licensing rules will 'protect public health and nutrition' is misleading.

Third, private 'partnerships' in service delivery (also called 'participations', and a system of 'provider pluralism') are called for, including health insurance schemes, on the basis of providing increased resources to the sector. These are then linked to World Bank administered 'Poverty Reduction Strategies' (OECD, 2003), which are in turn designed to enforce the entry of private for-profit companies. This call for private 'participation' is accompanied by a demand for 'the provision of public subsidies to non-government providers... [including] commercial providers' (OECD, 2003, p. 44). This will often mean that subsidies for foreign private companies are added to the 'development debt' of developing countries.

While the OECD guidelines recognize the obvious fact that 'user fees' deter poor people from seeking health services, they then urge a 'cautious' approach to user fees. They go on to spell out circumstances where such fees 'may be appropriate... [for the] private for profit' agencies. These agencies are in turn linked to a wider 'private sector', including NGOs, which the OECD wants to encourage into the 'partnerships' of poor countries' health systems. The circumstances in which user fees could be 'cautiously' applied include fees forn hospital and specialized services for those who can afford to pay, and an NGO-led 'community setting' of appropriate fees (OECD, 2003, pp. 42–48).

The franchising of health services in developing countries (for example US-backed family planning clinics in Mexico and the Philippines) is one commercial device to extend market access for First World corporations, but it also carries potential conflicts of interest. Dominic Montagu (2002) discusses the problems of quality control in this area, and warns of the danger of conflicts between 'social goals and provider satisfaction'.

The OECD guidelines are once again supplemented in this area by its country-wise policy reports. In Mexico, the OECD strongly backed policies of 'competitive service provision', 'consumer choice', user fees, payroll tax reductions and general deregulation of health agencies (OECD, 1998, pp. 100–105). While decentralization of health programs can encourage valuable participation, the fragmented nature of Mexican health services hardly cries out for *more* competitive service provision. To the extent that these forms of privatization damage the construction of universal and well-coordinated systems, they will drain valuable resources, aggravate inequalities and damage the healthy futures of many millions of people.

Conclusion

The OECD emphasis on the expansion of health resources in developing countries through private supplementation—and a complementary downgrading of well-coordinated public systems with well-trained health workers—is a systemic attack driven by commercial interests and rank with hypocrisy. OECD countries with publicly integrated systems have consistently, and over many decades, produced the best basic health outcomes. Conversely, those countries with massive resources and poor coordination (such as the USA) have produced poor aggregate outcomes, as well as high levels of inequality. This pattern is more pronounced in developing countries.

The businesslike model of 'competitive service provision' and 'consumer choice'—as though public health were an optional commodity—is increasingly under attack in the OECD countries (TUAC, 2004), and is even less appropriate in developing countries.

Health and aid policies driven by covert privatization agendas carry great danger in developing countries, where deficient and unequal access to infrastructure and services is often fatal. Most importantly, a degree of honesty is required in the discussion of developmental health, so that clear conflicts of interest are identified and not collapsed together under the guise of 'policy coherence'. The demands of OECD water companies, pharmaceutical companies and health service contractors must be identified as distinct and potentially conflicting interests, to be managed in the interests of integral public health.

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