annd
Arab NGO Network for Development
شبكة المنظمات العربية غير الحكومية للتنمية

AMERICAN UNIVERSITY OF BEIRUT
FACULTY OF HEALTH SCIENCES

NEOLIBERAL GLOBALIZATION AND HUMAN RIGHTS

2023

A right to health model

Mohammed Said Al-Saadi

Political Economy Researcher

This report is published as part of the Arab NGO Network for Development's Arab Watch Report on Economic and Social Rights (AWR) series. The AWR is a periodic publication by the Network and each edition focuses on a specific right and on the national, regional and international policies and factors that lead to its violation. The AWR is developed through a participatory process which brings together relevant stakeholders, including civil society, experts in the field, academics, and representatives from the government in each of the countries represented in the report, as a means of increasing ownership among them and ensuring its localization and relevance to the context.

This 6th edition of the AWR focuses on the Right to Health. The AWR 2023 on the Right to Health is a collaboration between the Arab NGO Network for Development and the Faculty of Health Sciences at the American University of Beirut. Through this report we aim to provide a comprehensive and critical analysis of the status of the Right to Health in the region and prospects in a post COVID-19 era. It is hoped that the information and analysis presented in this report will serve as a platform to advocate for the realization of the right to health for all.

The report is published by the **Arab NGO Network for Development** (ANND). It can be obtained from ANND or can be downloaded from the following website: **http://www.annd.org**

SUPPORTED BY

Brot für die Welt | Norwegian People's Aid | People Change the World Diakonia

NEOLIBERAL GLOBALIZATION AND HUMAN RIGHTS

A right to health model

Mohammed Said Al-Saadi

Political Economy Researcher

Mohammed Said Al-Saadi is an economist and independent consultant. He has written numerous books and publications on Business groups and Development, the Moroccan Economy, Gender and Euro-Mediterranean Partnership, and is a social activist. His research topics cover rethinking development models and developmental states, the impact of the neoliberal and global crisis on Arab countries, industrialization and industrial policies.

CONTENTS

INTRODUCTION

The past four decades of human history have witnessed the expansion of neoliberal globalization across a large portion of the globe. In its economic dimension, this expanse was based on the postulate that focusing on macroeconomic stability (particularly by controlling inflation and reducing government budget deficit), liberalizing the economy by activating market mechanisms, privatizing public enterprises (or institutions) and facilities, removing obstacles hindering the free flow of goods, services, and capitals, would put an end to rentier activities, promote competition, improve available opportunities for exportation, and help narrow the gap between individual income in poor states and those in wealthy states. These promises never crystallized into tangible reality. They became illusions (السعدي/Al-Saadi 2022), particularly in terms of improving the growth rate and reducing differences between (and within) countries. It gets worse when it comes to the implementation of internationally-recognized economic, social, and cultural rights, most notably the right to health for everyone.

This report attempts to highlight the correlation between neoliberal globalization and human rights with a focus on the right to health. We relied on available academic research and studies as well as outputs and statistics published by international, regional, and national organizations. The report explicates the negative effect of neoliberal globalization on economic rights, particularly the right to health, and sheds light on the mechanisms producing these negative outcomes.

The first section of the study will present the concept of neoliberal globalization and the role of international financial institutions (the International Monetary Fund (IMF) and the World Bank specifically) in its world expansion, especially in the global south, also known as the developing countries. These institutions use conditionality to impose structural adjustment programs (SAPs; also called "economic reform") based on the economic liberalization, privatization, and austerity trifecta. We demonstrate the negative effect of these programs by focusing on the right to health.

The second and third sections will focus on the Arab region as a case study. In the second section, we address the effects of

austerity policies on the implementation of the right to health for all citizens, while the third and final section showcases how privatization of the health sector and business agreements negatively affect the right to health.

NEOLIBERAL GLOBALIZATION, INTERNATIONAL FINANCIAL INSTITUTIONS, AND HUMAN RIGHTS

THE EVOLUTION OF THE GLOBALIZATION PHENOMENON AND THE ROLE OF INTERNATIONAL FINANCIAL INSTITUTIONS

Globalization is not a new phenomenon despite the excessive use of this term in scientific, journalistic, financial, business, and public opinion rhetoric. It is an organic by-product of capitalism due to the latter's tendency to spread internally (by dominating the various facets of economic, social, cultural, and environmental life) and geographically, to ensure the continuity of capital accumulation and profit maximization. Three main historical phases can be identified in the evolution of globalization: colonialism, "constrictive" globalization, and neoliberal globalization.

Colonialism was the direct expansion by western major powers across the globe due to their race to occupy different parts of the world for economic and strategic reasons. These powers were seeking new markets for their industrial products and financial investments while controlling the raw material and agricultural resources necessary for their economies. This colonialist phase of globalization ingrained vulnerability and dependency on the fluctuations of raw material prices in the colonized global south. This situation lasted from the last quarter of the 19th century until the end of World War II (WWII).

Constrictive and "negotiated" globalization (meaning that "the governments and peoples of Asia and Africa, the Soviet Union, and the United States and their allies created a multipolar negotiating structure that governs the world order" (العولمة وبدائلها 2018). The constrictive aspect of capitalist globalization is due to post-WWII circumstances, where labor unions and parties in developed capitalist countries were able to impose a power balance that resulted in the adoption of the welfare state model and the domination of the Keynesian ideology on public policies. Capitalism had to adapt to the requirements of social relations.

Nevertheless, this globalization soon started to lose its luster

in the beginning of the 1970s with the rise of inflation and recession. This flung the doors wide open for the transition to neoliberal globalization with Margaret Thatcher's and Ronal Reagan's ascension to power in Britain and the United States in 1979 and 1980 respectively.

Neoliberal Globalization: this phase was marked by capitalism regaining the upper hand. It imposed its political project and economic agenda that are based on a "liberal economy" and prodded governments to decrease taxes, lift restrictions on the banking and financial sector, and reduce labor costs by creating labor market "flexibility." As a result, capitalist developed countries would adopt the trifecta of economy "liberalization", privatization, and maintenance of macroeconomic balances aimed at creating the appropriate climate for activating market mechanisms. These alone could achieve optimal employment of available resources.

INTERNATIONAL INSTITUTIONS AS KEY ACTORS TO IMPLEMENT NEOLIBERAL GLOBALIZATION: STRUCTURAL ADJUSTMENT PROGRAMS

Following WWII, the Bretton Woods Institutions were established. These comprised the IMF, the World Bank (WB), and the General Agreement on Tariffs and Trade (GATT), which would later become the World Trade Organization (WTO) in 1995. These institutions aimed to ensure the evolution and stability of the global capitalist system led and controlled by the United States through free trade exchange and an international monetary and financial framework. However, in 1971, the United States decided to suspend the dollar's convertibility into gold (one of the most important pillars of the Bretton Woods system). This led to a structural crisis and a transformation in the duties of the two international financial institutions (the IMF and World Bank). Subsequently, these two institutions would approach third world countries drowning in external debt to ensure they pay their creditors, essentially to save developed capitalist countries' banks. These aforementioned institutions would impose harsh conditionality in exchange for loans aimed at having the debtors forsake their state-directed economic model for the sake of a model that is based on liberal markets, free initiative, and a redirection of the economy towards exportation. This is the "structural adjustment" that was imposed on countries, also known as the "Washington Consensus" (between the US Department

of the Treasury, the IMF, and the World Bank) (Stiglitz & Pike 2004), based on the economic liberalization, privatization, and austerity trifecta.

It is worth noting that the main goal of these programs was to integrate the global south into the globalized capitalist system and to respond to the expansion needs and additional capital accumulation, and world domination of major monopolies and multinational companies (Petras & Veltmeyer 2011). Percy Barnevik, CEO of ASEA Brown Boveri, put this reality into simple words in his definition of globalization: "I would define globalization as the freedom for my group of companies to invest where it wants when it wants, to produce what it wants, to buy and sell where it wants, and support the fewest restrictions possible coming from labor laws and social conventions" (Chesnais 1997). Structural adjustment and stabilization programs consist of restoring macroeconomic balance (controlling inflation, balancing the public budget and the balance of payments), gradually liberating industrial, trade, and financial sectors, privatizing public sector companies, and lifting administrative and regulatory restrictions on private sector initiatives. The restoration of macroeconomic balance requires applying strict austerity policies such as reducing public expenditure, wage bill cuts/caps, eliminating subsidies on basic goods, while economy liberalization is conducted through more liberal trade policies, liberalization of the exchange rate and prices in general.

In terms of controlling and rationing, the expected changes mainly aim to "improve the business climate", i.e., government measures regulating private sector activities, including the labor law, to make work relations more flexible.

If the role of the IMF stalled during the first decade of the 21st century, it made a strong comeback with the global financial crisis of 2008, especially after the emergence of the European sovereign debt crisis due to the state's extensive intervention to save the financial and banking sector from collapsing. The most notable measures that were taken to implement structural adjustment programs and austerity policies against the European sovereign debt crisis were: phasing-out or eliminating subsidies on basic goods such as fuel, electricity, food items, and agricultural inputs, wage bill cuts/caps, increasing taxes on sales and value-added tax (VAT), "reforming" pension systems, privatizing public facilities, and applying labor flexibility, etc. (السعدي/Al-Saadi 2022).

NEOLIBERAL GLOBALIZATION AND HUMAN RIGHTS (PARTICULARLY THE RIGHT TO HEALTH)

THE EFFECTS OF STRUCTURAL ADJUSTMENT PROGRAMS (SAPS) ON HUMAN RIGHTS

Due to considerations related to the space allocated to this report, we will present the connections between neoliberal economic policies and certain economic and social rights. For a more thorough analysis of these connections see (Balakrishnan & Elson 2011). We will expand more on this subject in the section related to the right to health.

A group of UN experts conducted a careful review of the documents and publications resulting from 20 years of structural adjustment in Africa and Latin America. This review concluded that "these policies were not consistent with the long-term developmental needs of developing countries. The available evidence refutes the claims of the World Bank and the IMF that SAPs reduce poverty and promotes democracy. SAPs use the principles of liberal economic activity to emphasize efficiency and productivity and is biased towards groups that exercise exportation and international trade at the expense of civil freedom and autonomy" (1999 آثار سياسات التكيف الهيكلي/ The Effects of Structural Adjustment Policies). This impact is the most evident on the levels of the rights to work, food, and education.

The right to work

The International Covenant on Economic, Social and Cultural Rights (ICESCR) acknowledges every person's right to "just and satisfactory" work conditions. This means having fair wages and equal pay for equal work that is sufficient to provide a decent life for workers and their families. Article 8 acknowledges the worker's right to form or join unions that protect their right to strike. This article emphasizes safe working conditions, equal opportunity in the workplace, and sufficient periods of rest and free time, including defined working hours and regular paid vacations. The ICESCR also urges the World Bank and the IMF to take into consideration the need to protect the right to work in adopted loan-related policies.

However, it is worth noting that "reforms" recommended by these institutions directly harm the right to work in just conditions by focusing on the flexibility of the labor market,

claiming that the latter is a decisive factor in improving the competitiveness of goods and services in borrowing countries. Critics have highlighted that the IMF and World Bank often underestimate the negative repercussions of "labor flexibility" in relation to human rights. And so, the report of the United Nations Human Rights Committee confirms that policies pushing for "labor flexibility" are considered a violation of human rights (United Nations General Assembly, 2016). Additionally, a number of neoliberal economic "reforms" negatively and indirectly impact the protection of workers' rights. Liberalizing trade and attracting foreign investments are a downward spiral that is heading away from the respect of workers' rights, where local capital pushes decision-makers to reduce wages so they can keep up with global competition. Moreover, severe monetary policies prod governments to abandon wage-related workers' rights (such as minimum wage), using the resulting inflation as argument (Stubbs & Kentikelenis 2017).

The right to food

Applying SAPs resulted in a real threat to food security for large portions of global south societies. UN experts affirm that malnutrition and unemployment have increased among the poor due to the elimination of food assistance. Changing agricultural policies – from production for local consumption to production for exportation, such as coffee beans, cotton, or tobacco – has led to a sharp decline in food production and a rise in malnutrition (1999 آثار سياسات التكيف الهيكلي/The Effects of Structural Adjustment Policies).

The right to education

International conventions consider that every person has a right to education (Article 26 of the Universal Declaration of Human Rights). It was noted that SAPs contributed to the reversal of some of the achievements made by a number of "developing" countries in children's education during the 1960s and 1970s. This is essentially due to reducing spending on education. Primary education was negatively affected as the United Nations Educational, Scientific and Cultural Organization (UNESCO) has registered a decrease in 6- to 11-year-old children's enrolment in schools. This could influence gender equality as parents will refrain from enrolling their daughters in school when having to choose who will receive an education, due to the increase in school fees. This discrimination could have negative, long-term effects on the health of infants and children considering the vital relation between the child's well-being and the mother's level

of education (1999 آثار سياسات التكيف الهيكلي/The Effects of Structural Adjustment Policies).

The right to housing

Low or reduced wages and unemployment due to the implementation of SAPs prevent many households from fulfilling their basic needs, especially in terms of housing. In addition, the elevated interest rates annihilate any hope of purchasing a home. Moreover, as the state refrains from providing housing directly or through assistance to disadvantaged households and lifts the restrictive rental market controls, private property owners are more likely to take advantage of the poor, who often allocate a significant amount of their income—almost half—for rent (آثار سياسات التكيف الهيكلي 1999/The Effects of Structural Adjustment Policies).

■ THE EFFECTS OF NEOLIBERAL GLOBALIZATION ON THE RIGHT TO HEALTH

The International Covenant on Economic, Social and Cultural Rights (ICESCR) includes the most comprehensive article related to the right to health in international human rights law. According to Article 12 of the Covenant, "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", in addition, for instance, it refers to a number of "steps to be taken by the States Parties...to achieve the full realization of this right". However, the "neoliberal reforms" included in the SAPs, namely pressuring public expenditure, lifting regulatory controls, and privatizing the health sector negatively affected the realization of this right according to international legislations. To analyze the negative repercussions of these "reforms", we utilize the conceptual framework developed by Kentikelenis (2017), which looks at the multiple pathways through which SAPs promoted by the IMF and World Bank affect health systems, including through direct effects channels, indirect effects channels (moderated through macroeconomic and institutional reforms), and the impact of SAPs on the social determinants of health. The framework and various channels are described further below Kentikelenis (2017).

Direct effects channels

First: Stabilization policy and austerity measures reduce public health expenditure. This may affect investments in particular, and subsequently health services (the available number of health facilities for instance). In turn, we notice that the agreed SAPs between international financial institutions (IFIs)

and Latin American countries have led to decreases in public expenditures on social policy and social security, but increases in health spending.

Second: The healthcare workforce is also affected due to redundancies, hiring freezes, and wage bill cuts (by setting maximum wage), leading to the migration of healthcare workers.

Third: User fees for access to healthcare services reduce vulnerable groups' ability to access these services.

Fourth: Lifting regulatory controls contributes to the growth of the private health sector. This transformation was associated with social class discrimination, as strata of the population able to afford private healthcare can gain access to a broader bundle of services. However, this may be coupled with the state rolling back public provision to a limited array of services for the poor or outsourcing it to non-governmental organizations. As a result of these direct effects on the right to health, non-state actors have often been sought to fill the gap (particularly international organizations and civil society associations).

Indirect effects channels

First: Local currency devaluation leads to increases in prices of exported medications and medical equipment, making them harder to acquire, especially for low-income and vulnerable groups.

Second: The removal of tariffs and customs reduces trade tax revenues in the short-run, which can undermine the financial resources for the health sector. However, public revenues may increase if growth rates improve due to more openness.

Third: The privatization of public sector institutions increases public revenues. However, these could be harmed in the medium- and long-run once revenues generated by state-owned enterprises are lost.

Effects on social determinants of health

Social determinants of health: the realization of the right to health does not solely entail an endeavor to eradicate diseases, but also its root causes. Beyond their effects on health systems, neoliberal policies can have a profound impact on the social determinants of health that could outlast the implementation period of SAPs. These four key effects are:

First: SAPs can result in a significant decrease in incomes and increases in unemployment and poverty, with follow-on effects

on social class inequalities. These in turn are root causes of health problems that could last a lifetime.

Second: Education is a key social determinant of health, as it improves individuals' knowledge about health and how to access health services, and positively impacts social mobility opportunities, which in turn feed into a host of other determinants of health (such as employment and income), yet neoliberal policies do not improve, but rather impede, access to education, especially for women and children. For example, the World Bank and IMF recommended the introduction of user fees for primary education or mandated education workforce reduction, thereby impeding educational attainment for children (1999 اثار سياسات التكيف الهيكلي/The Effects of Structural Adjustment Policies).

Third: The implementation of SAPs negatively impacts the environment and environmental policies, including water, sanitation, agriculture, and energy. For instance, IFI-mandated policies can result in environmental degradation, which in turn affects population health. In addition, the privatization of water distribution may render access more difficult for limited-income groups. These are all factors that may aggravate populations' health in the long run. Last but not least, the implementation of SAPs threatens social cohesion, changes cultural norms and societal values, and leads to a retreat to individualism and selfishness at the expense of public interest.

AUSTERITY POLICIES AT THE EXPENSE OF THE RIGHT TO HEALTH IN THE ARAB REGION

Arab States (we focus in this research on middle-income countries, intentionally excluding Gulf countries), like the rest of the global south, witnessed the implementation of neoliberal policies within the framework of SAPs during the 1980s and the 1990s. These policies negatively impacted the right to health, either directly by marginalizing the public health sector, or indirectly through its repercussions on social determinants of health (unemployment and poverty, aggravated social class inequality, reduced level of education, etc.). Despite adopting the slogan of "health for everyone" and relying on the government to fulfill the majority of essential health needs, most Arab States faced qualitative obstacles such as reduced human resources and decreased levels of professional competence. This was coupled with a limited fiscal basis due to the pressures imposed on public expenditure, privatization policies, and commercialization of social services, leading to disparities in mortality and sickness rates along with inequality between income groups, in terms of gender, and geographical location (الفضيل/Fudayl 2012; بيومي/Bioumi 2016).

What interests us in this section is highlighting the negative effects of the continued implementation of neoliberal policies, and especially austerity measures, in the health sector post-Arab Spring and the resulting unpreparedness of several Arab States to address COVID-19. We will present the austerity policies that were adopted in the wake of the Arab Spring before analyzing its repercussions on the right to health in the Arab region.

THE CONTINUED AUSTERITY POLICIES POST-ARAB SPRING

THE INTERNATIONAL MONETARY FUND POLICIES POST-ARAB SPRING

The IMF justifies the need to resort to austerity policies and its neoliberal components with the deceleration of global growth and economic recession in the Eurozone, in addition to increases of food item and fuel prices and the expansion of the Syrian crisis repercussions to neighboring countries. It

also mentions the post-Arab Spring internal factors marked by uncertainty and the faltering of current political reforms with governments increasing support for basic goods despite the continued significant funding needs (السعدي/Al-Saadi 2022).

As a way out of this situation, the IMF considers it a priority to maintain external and financial sustainability and reduce public debt. This requires activating the instruments of the public financial policy and monetary policy "to provide the conditions for comprehensive growth across all of society's sectors". On the one hand, public financial affairs must be controlled, public investments must be rationalized, and social safety nets for the poor must be strengthened. On the other hand, a cautious monetary policy against inflation must be adopted, currency exchange rate flexibility must be promoted, and structural reforms must be continued (review the labor market regulatory framework, reform, organize the business sector and governance, improve funding acquisition).

By laying out its vision, it is clear that the IMF is adopting the same approach we presented earlier: controlling budget deficit considers austerity policies an important factor to restore confidence in the private sector perceived as the driver for economic growth.

AGREED AUSTERITY MEASURES WITH THE IMF IN RETURN FOR LOANS OR THROUGH MONITORING REPORTS UNDER ARTICLE IV OF THE IMF'S ARTICLES OF AGREEMENT

Despite the Arab Spring, governments in the Middle East and North Africa (MENA) region adopted an average of three austerity measures per country to control their public budget deficit (Ortiz & Cummins 2013).[1] Furthermore, countries also adopted wage bill cuts/caps and reviewing support programs and tax systems. Eliminating subsidies on basic goods (particularly fuel and food items such as flour, sugar, and oil) was the common measure between all Arab States included in the review by Ortiz and Cummins (2013), with the exception of Lebanon, despite its political and social implications, especially in the absence of comprehensive social protection policies in Arab States. In contrast, there were other "reforms" under study by governments in the region, such as increasing indirect taxes (VAT), decreasing tax exemptions, controlling wage bills, and reducing public institutions' running costs. Moreover, other states were planning on reconsidering "reforms" in pension systems (Tunisia) or reviewing their healthcare policy (Jordan) by rationing health spending and using pharmaceuticals (Ortiz & Cummins 2013).

[1] This average is based on an analysis conducted by Ortiz & Cummins, who analyzed 314 IMF country reports published between January 2010 to February 2013. Their study of 181 countries covered the following 10 countries in the Middle East & North Africa: Algeria, Djibouti, Egypt, Iran, Iraq, Jordan, Lebanon, Morocco, Tunisia, and Yemen (Ortiz & Cummins 2013).

A study of the adopted measures between 2012 and 2015 has shown that promoting austerity harms development and social progress (Ortiz et al. 2015).[2] An analysis of the study findings offers the following conclusion: all governments in countries in the MENA region covered by the study focus on "reforming" the state's subsidies on basic goods, particularly fuel, and food items sometimes, among others. Other common measures among all MENA countries covered by the study include: wage bill cuts/caps and "reforming" the labor market. On the one hand, Egypt has taken the decision to implement wage bill cuts, comprehensively review public wages system, and reduce pensions. Other countries followed suit, such as Algeria, Morocco, and Jordan. On the other hand, Algeria, Egypt, Jordan, Morocco, and Tunisia opted for introducing labor market "flexibility" by reducing regulatory controls and improving education programs (Ortiz et al. 2015).

EFFECTS ON THE RIGHT TO HEALTH

IFI-imposed conditionality in the form of "fiscal adjustment" negatively affects the right to health through the numerous channels it is applied, most notably reducing government budget deficit, imposing restrictions on workforce employment, and exerting pressure on public investment in the health sector. We shall discuss the effects of these respective three channels on Arab States.

LIMITING PUBLIC EXPENDITURE ON HEALTH AND CHARGING THE CITIZEN WITH A LARGER PART OF MEDICAL AND TREATMENT BILLS

Figure 1 demonstrates the evolution of the "per capita total expenditure on health" between 2000 and 2019 in selected Arab States, excluding the Gulf states, for numerous considerations, most notably financial wealth, population size, and their ability to import foreign medical expertise. This indicator has witnessed considerable growth in countries such as Jordan, Tunisia, Algeria, and Egypt, and not as much in Lebanon, Morocco, and Iraq between 2000 and 2008. The same applies to the growth rate curve of "total health expenditure in relation to growth domestic product (GDP)" (**Figure 2**). The curve of this indicator rose between 2000 and 2008 in Tunisia, Morocco, and Egypt while it rose to a lesser degree in Morocco, Lebanon, and Iraq. The global economy witnessed

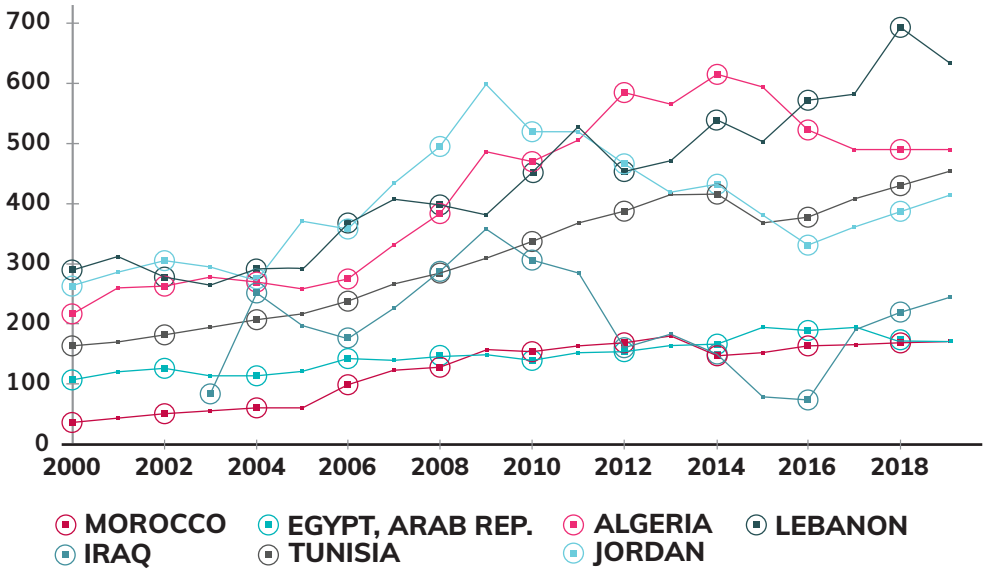
[2] The study by Ortiz et al. (2015) offers an analysis of 284 IMF country reports published from September 2012 to February 2015. Their study of 187 countries covered the following eight countries in the region: Algeria, Egypt, Iran, Jordan, Lebanon, Morocco, Tunisia, and Yemen.

significant recovery during the reported period, marked by "financialization" and the emergence of real estate and financial bubbles in the United States and Europe.

However, these bubbles exploded in 2008 leading to a global financial crisis that would cast its shadow on a number of countries across the world as of 2010. Subsequently, the European Union and many Arab States adopted austerity policies that would negatively impact their economic and social situations, including the health sector as of 2011-2013. The "total health expenditure per capita" tangibly decreased in varying percentages from one Arab country to another between 2012 and 2019. The same decrease was noted in the growth curve of "public health expenditure in relation to GDP" with significant dwindling in countries such as Egypt, Tunisia, and Algeria.

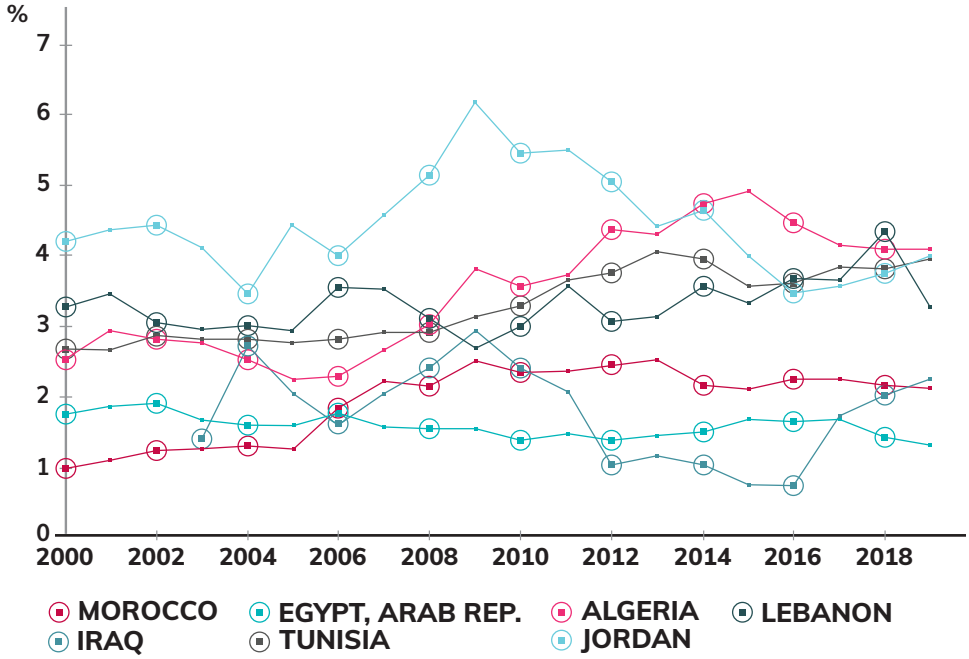
To make the picture clearer, we chose the "the general increase in health expenditure" in Morocco as an example, which registered a tangible decrease from 2010 to 2016 (**Figure 3**).

Figure 1. Domestic general government health expenditure per capita, purchasing power parity (current international dollar): Morocco, Egypt, Tunisia, Algeria, Lebanon, Jordan, and Iraq



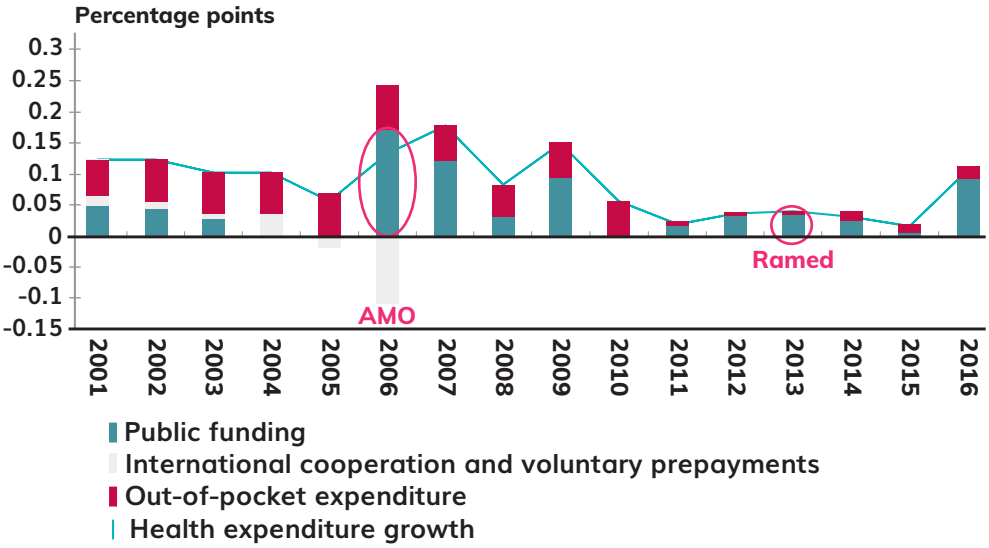
Source: World Bank, World Development Indicators

Figure 2. Domestic government health expenditure (% of GDP): Morocco, Egypt, Tunisia, Algeria, Lebanon, Jordan, and Iraq



Source: World Bank, World Development Indicators

Figure 3. Detailed growth of health expenditure in nominal terms in Morocco



Source: Mobilizing tax revenues to finance the health system in Morocco, OECD: Global Health Expenditure (WHO), 2020.

Given the reduced total expenditure on health, citizens are forced to carry the larger part of their medical and treatment

needs. If we exclude the Arab Gulf region where state contributions cover at least 60% of these needs, the citizen pays the more significant share of medical needs in several countries in the region, especially in Egypt, Yemen, Syria, Iraq, and Morocco (**Table 1**).

Table 1. Financial health indicators (out-of-pocket (OOP) spending)

Country	OOP as % of health expenditure		
	2006/08	2015	2020
Egypt	57.4	58	62
Iraq	22.2	36.5	78.5
Jordan	42.9	23.5	30.4
Lebanon	41.2	34.3	33.1
Libya	28.3	29.7	26.5
Morocco	57.2	58.4	-
Sudan	70.2	75.8	73.9
Syria	52	53.9	-
Tunisia	45.6	35.3	39.9
Yemen	47.5	74.1	-

Source: WHO EMRO Health Indicators

EFFECTS ON WORKFORCE IN THE HEALTH SECTOR

Reducing total expenditure on health as part of austerity measures that prioritize macroeconomic balances, at the top of which is reducing budget deficit to 3% of the GDP, exerts pressure on wage bills, thus blocking or reducing employment to the maximum limit and/or eliminating pensions, as well as favoring fixed-term employment contracts (also known as contracting in certain Arab States such as Morocco), or wage cuts/caps.

Reducing employment

No data reflecting the evolution of the public health sector workforce in the Arab region was found. This is due to the fact that the World Health Organization (WHO) does not segregate statistics according to gender and sector (private or public). Taking this reservation into consideration, **Table 2** indicates that the average number of physicians for every

10,000 people has decreased between 2014 and 2019 in five countries (Algeria, Egypt, Iraq, Morocco, and Syria) out of 10 or has remained the same in Tunisia and Libya, while registering an increase in three countries (Jordan, Lebanon, and Sudan). Similarly, and over the same period, the rate of female and male nurses (**Table 3**) decreased in six countries out of 11 (Algeria, Egypt, Libya, Sudan, and Syria), while it increased in five others (Iraq, Lebanon, Morocco, Tunisia, and Yemen). In general, the public health sector funding issue, further aggravated by austerity policies, remains a major obstacle hindering the improvement of health services in Arab States. These countries are falling behind in terms of medical and nursing human resources compared to the global average and the Gulf region (see **Figures 4 and 5**).

Table 2. Health sector workforce (Physicians)

Country	Medical Physicians					
	2014	2015	2016	2017	2018	2019
Algeria	-	-	18.42	-	17.32	-
Egypt	7.45	7.77	7.77	7.57	7.3	7.09
Iraq	9.71	-	8.08	7.94	6.7	9.13
Jordan	22.7	27.4	-	22.2	-	25.13
Lebanon	20.6	21.4	21.5	22.6	24.25	26.17
Libya	21.4	19.6	-	21.5	-	-
Morocco	9.1	-	-	7.3	-	-
Sudan	-	4.15	-	-	11.4	-
Syria	14.4	-	11.8	-	-	-
Tunisia	12.3	12.6	12.4	12.6	-	-
Yemen	2.9	-	-	-	-	-

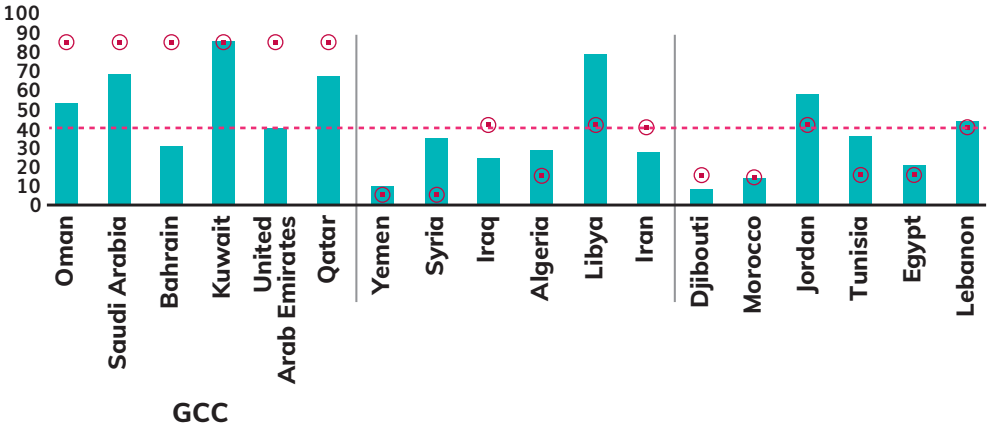
Source: WHO EMRO Health Indicators

Table 3. Health sector workforce (Nurses)

Country	Nursing Personnel					
	2014	2015	2016	2017	2018	2019
Algeria	-	-	22.5	22.3	13.45	-
Egypt	18.49	18.3	18.2	18.2	18.27	-
Iraq	17.24	15.54	16.2	16.2	19.3	21.1
Jordan	31.8	-	-	28.6	26.8	28.14
Lebanon	14.3	14.4	15.6	16.6	17.4	-
Libya	70.8	-	-	65.7	-	-
Morocco	8.6	-	-	12.7	-	-
Sudan	12.3	8.4	-	-	-	-
Syria	21.5	-	14.1	-	-	-
Tunisia	23.8	25.3	25.7	24.9	-	-
Yemen	6.7	6.7	6.9	7.1	7.2	-

Source: WHO EMRO Health Indicators

Figure 4. Number of qualified health professionals per 10,000 people



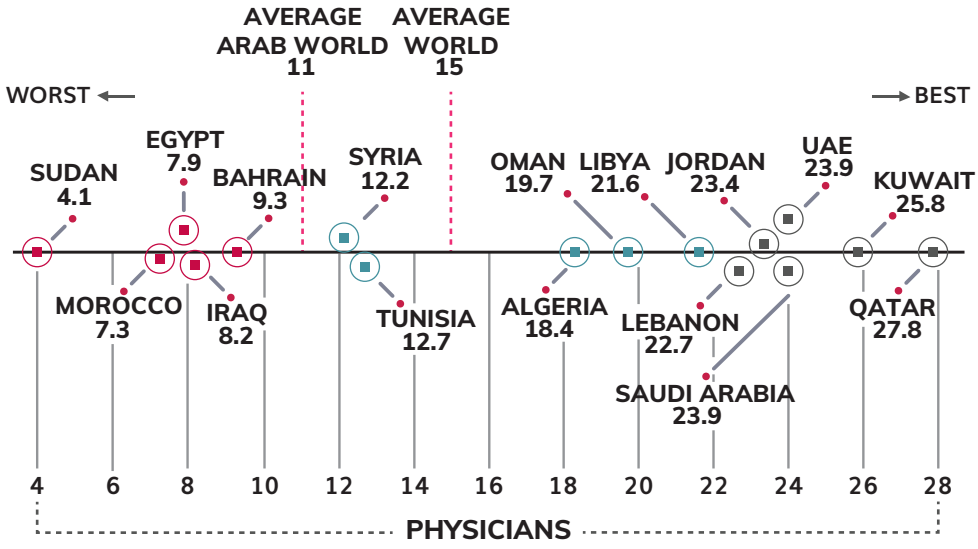
National value

Comparison to the median value of the income bracket

2014 data, except for Oman, 2016; Kuwait, Bahrain, Jordan and Tunisia, 2015; Algeria, 2017. GCC countries are compared to the median value of high-income countries; all other countries are compared to the median of middle-income countries.

Source: Organisation mondial de la santé, Observatoire mondial de la santé

Figure 5. Number of physicians per 10,000 people



Richer Arab countries are doing better in terms of physician density, but they are still below the global average of high-income countries, which stands at 30.

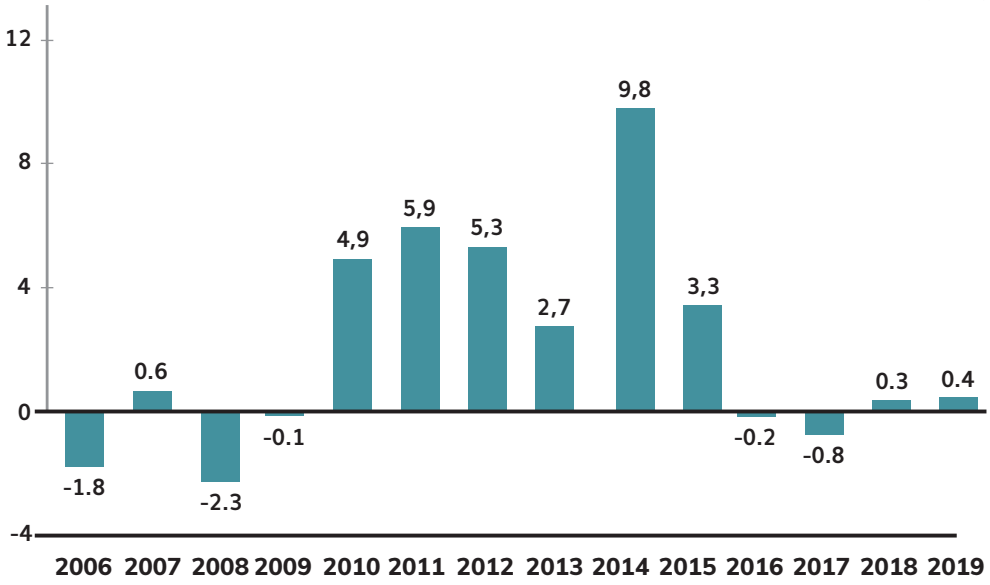
Source: From World Bank

Pressure on wages

Arab region governments prioritize the implementation of international institutions' instructions to control inflation and reduce budget deficit. This leads to their resorting to wage reduction as a mechanism to achieving these two objectives. **Figure 6** indicates the reduced purchasing power of the Arab region's workforce in general. The annual average real wage growth decreased significantly in 2015, registering a percentage of 3.3% (compared to a growth rate of 9.8% in 2014), before slipping to 0.5% in 2016 and 0.8% in 2017. 2018 and 2019 witnessed a slight increase of 0.3% and 0.4% respectively.

Moreover, wage bill cuts or caps have negative repercussions on human development. Many middle- and low-income Arab States suffer from a major deficiency in available human resources such as male and female physicians, nurses, teachers, and social workers. For instance, the shortage in health professionals in Morocco is estimated at "97,000 professionals in the medical and paramedical fields, and the country needs 25 years to fill the gap in human resources in the health sector" (24اليوم/Alyouwm24 2021). The reduced purchasing power of health sector workers is expected to affect their morale, decrease their productivity, increase absence from work and work in the informal sector, and aggravate human capital and competencies flight. This reflects negatively on public services offered to citizens, especially in the popular areas of rural and urban regions.

Figure 6. Annual average real wage growth in the Arab region (2006-2019)

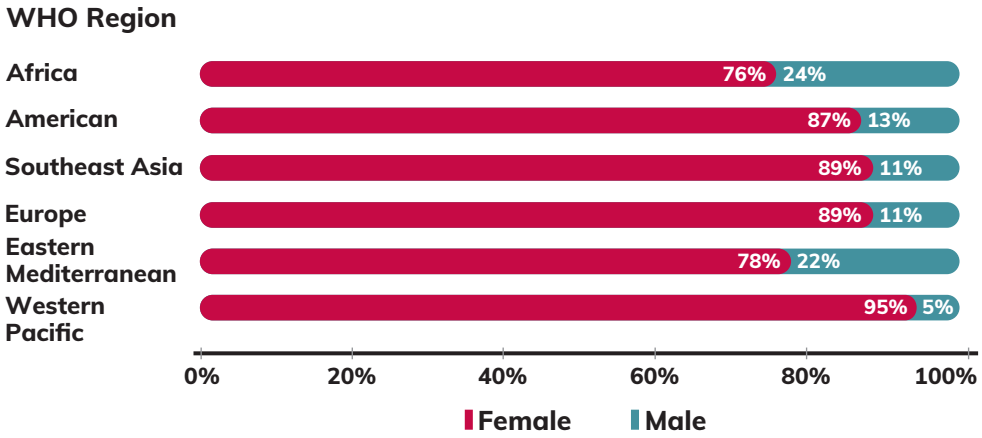


Source: Global Wage Report, 2020-2021

Female health workers are the most affected by the deterioration of work conditions due to austerity policies in the health sector

The global health sector depends on the services of female workers more than male workers. **Figure 7** shows that women form 78% of nursing staff in the Middle East (this region includes all Arab States except Algeria) compared to 22% of men. In contrast, few women occupy leadership and responsibility positions as nurses or physicians. WHO data indicates that women are paid less than men, along with facing other forms of workplace gender-based discrimination (Organisation Mondiale de la Santé 2020).

Figure 7. Percentage of female and male nurses by region



Source: Organisation Mondiale de la Santé (OMS), 2020

NEGATIVE EFFECTS ON INVESTMENT IN THE PUBLIC HEALTH SECTOR

Given the lack of consolidated data on investment in health in the Arab region, the number of available hospital beds and the number of primary healthcare units and centers provided in WHO reports were used to measure the evolution of investment in the health sector over the past decade. It is worth noting that the two mentioned indicators do not reflect the share of each of the private and public sectors in health investments.

Table 4 shows the evolution of the hospital beds and primary healthcare units and centers indicators for every 10,000 people between 2008, 2015, and 2020. The hospital beds indicator for every 10,000 people decreased in nine countries out of 12 (excluding Gulf countries for previously explained reasons). Egypt, Jordan, Lebanon, and Libya witnessed a significant dive in this field.

As for the primary healthcare units and centers indicator, it decreased in nine cases out of 10. It is worth noting that the number of hospital beds for every 10,000 people in Arab countries remains below the global limit set at 18 (WHO, SDG Indicator Metadata, 20-12-2021).

Moreover, researchers have noticed that austerity policies in the health sector reflect negatively on preventative care spending compared to curative care despite the former's importance in pandemic prevention (Jacques & Noël 2022).

Table 4. Health-related material resources' indicators (% for every 10,000 people)

Country	Hospital Beds				Primary Healthcare Units and Centers			
	2006/09	2015	2020		2006/08	2015	2020	
Bahrain	19.7	20.3	17.8		0.2	0.2	0.2	
Djibouti		20.3				0.6		
Egypt	20.8	14	14.3	↘	0.7	0.6	0.6	↘
Iraq	12.6	15.6	12	↘	0.6	0.7	7.1	↗
Jordan	18	13.8	14	↘	2.4	2.3	7	↗
Kuwait	18	20.4	19.3		0.4	0.3	0.2	
Lebanon	34.3	28.5	27.3	↘		2.3	0.5	↘
Libya	37	37	32	↘	2.6	2.3	2.1	↘
Morocco	11	11	10	↘	0.8	0.9	0.8	↘
Oman	20.2	15.8	14.8		0.9	0.6	0.5	
Palestine	12.8	13.9	12.9	↗	1.8	1.3	1.6	↘
Qatar	25.2	12	11.2		2.7	2.3	3.2	
Saudi Arabia	22.1	26.5	22.5		0.8	0.7	0.7	
Sudan	7.3	80.1	6.6	↘	1.6	16	1.5	↘
Syria	15.4	15	13.9	↘	1	0.9	0.9	↘
Tunisia	20	21.8	24	↗	2	1.9	1.9	↘
UAE	18.6	0.12	17.9		0.3	11	3.8	
Yemen	7	7.1	5.7	↘	2	1.5	1.4	↘

Source: WHO EMRO Health Indicators

AUSTERITY POLICIES IN THE HEALTH SECTOR DID NOT HELP RESPONDING TO COVID-19

If COVID-19 revealed the key role of socio-economic determinants in the spread of the virus, it also highlighted the unpreparedness of health systems to respond to such crises considering the noticeable shortage in human resources, insufficient medical equipment and facilities, the limited number of intensive care units, and the marginalization of preventative care at the expense of curative care. It also accentuated the weakness of the universal social protection system in the Arab region as an effective means to respond to the various, particularly health-related risks, that individuals may face throughout their lives. The repercussions of the pandemic were

more severe on vulnerable groups, especially in the informal sector and for vulnerable workers. This is confirmed by Alami (2022) as she writes that "the impact of the pandemic was aggravated by the weak health funding systems and the inadequacy of public sector social protection at the expense of the poor and vulnerable groups of society...[moreover], if the lack of medical oxygen and intensive care units was in itself an issue in responding to the pandemic, having a solid and evolved public health sector is considered a stronger line of defense to prevent this issue" (Alami 2022).

PRIVATIZATION, COMMERCIAL AGREEMENTS (INTELLECTUAL PROPERTY RIGHTS), AND THE RIGHT TO HEALTH

The neoliberal approach to health is considered a commodity regulated by the supply and demand "law" rather than a basic human right, as stipulated by international conventions. As per the approach, the government must allow the domestic and foreign private sector to develop this sector that is vital for society, as demonstrated by COVID-19. There are three key factors that contributed to the development and expansion of healthcare privatization: governments' narrow fiscal space (the outcome of anti-tax and social justice policies), the pressure exerted by multilateral international institutions, namely WTO and IMF, and bilateral trade agreements. We shall present the risks incurred by the expansion of the private sector in Arab States in terms of achieving comprehensive fairness and justice in the health sector. Then, we shall address international and bilateral agreements and their measures that could affect realizing the right to health, while focusing on the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in the Arab region, considering its direct impact on this context.

THE PRIVATIZATION OF THE HEALTH SECTOR AND ITS REPERCUSSIONS ON THE RIGHT TO HEALTH

The privatization of the health sector takes many forms. We cite private health insurance (the liberty to pay for customized services according to a contract that allows the insured to benefit from a set of services limited by a specific financial ceiling) at the expense of public funding or one that is based on social solidarity, the wide range of private healthcare offers, the refund of provided health services and the adoption the rules of "the new public management" (applying private sector work methodologies to public sector institutions while focusing on competencies, achieving flexibility, heading towards decentralization, and fixating on results), and importing certain services (such as cleaning and laboratory testing) (André et al. 2016).

The following section will focus on the expansion of private healthcare offers and financialization at the expense of the public sector while highlighting its negative effects on the right to health.

THE EVOLUTION OF HEALTH SECTOR PRIVATIZATION IN THE ARAB REGION: TOWARDS THE "FINANCIALIZATION" OF THE PRIVATE HEALTH SECTOR

The data on the expansion of the private health sector in the Arab region is not sufficient. The main data used to address this subject were extracted from a relatively recent World Health Organization (WHO) study (WHO 2018). We also relied on a recent study by the Moroccan Competition Council on private hospitals and similar entities (2022 وكالة المغرب العربي الأنباء). The World Bank defines the private health sector as "the official profit-oriented health service providers" (Harding & Preker 2003; mentioned in WHO 2018).

The private sector evolved exponentially during the 1990s due to numerous factors, including: the rise in demand for health services paralleled by a marginalization of the public health sector. In addition, increased profitability and poor enforcement of the tax system led to an increase in private investment in the health sector, especially by doctors.

The private health sector covers a variety of activities that are linked to inpatient and outpatient healthcare services, investment in infrastructure, medication production, and the importation and use of health technologies, with the exception of preventative healthcare which does not interest the private sector. In middle- and low-income Arab States, this sector provides between 33% and 88% of inpatient and outpatient healthcare services. Table 5 indicates the number of public and private sector hospital beds in several countries in the region. We notice a clear contrast between country Groups 1 and 2. Public hospitals in Group 1 are prevalent due to the large financial capacities of the Arab Gulf states, whereas private hospitals outnumber public hospitals in Group 2, which includes middle-income countries.

The private sector owns between 60% to 100% of the pharmacies in middle-income countries, while this percentage ranges between 22% and 98% in low-income countries. There is also a significant concentration of the private health sector in urban areas where the social groups who can afford it are present.

Table 5. Distribution of hospital beds in the private and public sectors

Country	Hospitals		Hospitals beds		Total	Percentage of private hospital beds	Hospital beds per 10 000 population
	Private	Public	Private	Public			
Group 1							
Bahrain	13	10	384	1 702	2 086	18	17
Kuwait	15	15	1 247	6 703	7 950	15	22
Oman[a]	10	55	360	5 499	5 859	6	16.7
Qatar	4	6		1 694			12
Saudi Arabia	137	298	14 165	46 871	61 036	23	21.4
United Arab Emirates	33	54	2 557	7 024	9 802	26	20
Group 2							
Egypt[a]	1 351	646	31 653	96 820	128 473	25	16
Islamic Republic of Iran[a]	170	682	17 323	114 232	131 555	13	17.5
Iraq[a]	231	96	2 886	40 182	43 068	7	13
UAE	18.6	0.12	18.6	0.12	0.12	0.12	0.12
Jordan[a]	61	45	4 041	8 065	12 106	33	18
Lebanon[a]	189	30	12 000	2 500	14 500	83	34.5
Libya	103	97	2 088	20 689	22 777	9	37
Morocco[a]	NA	141	7 973	21 734	29 707	27	9.3
Palestine[a]		40	1 174	5 183	6 357	18	15.2
Syrian Arab Republic	376	124	8 962	22 858	31 820	28	15.5
Tunisia[a]	116	174	3 400	19 632	23 032	15	23.0

(a): Data confirmed by WHO country office or Ministry of Health

Source: From WHO EMRO 2014.

TOWARD THE "FINANCIALIZATION" (THE PREVALENCE OF FINANCIAL PROFITABILITY AND ITS MECHANISMS) OF THE PRIVATE HEALTH SECTOR IN THE ARAB REGION

Foreign and domestic investment in the health sector is one aspect of health commercialization and its transformation into a lucrative service. Several Arab States are seeking to attract

private financial funds to join this "dynamic" by amending laws and legislations. As such, Law No. 131-13 on the practice of medicine in Morocco underwent significant amendments relating to the conditions of establishing and using private hospitals and similar entities and their regulating laws. In this context, the law allows for non-physicians to invest in these hospitals (particularly investment funds and insurance companies). Ever since, "hospital groups", also known as "health groups", appeared in the profit-oriented sector. These groups are mostly managed as a corporation. They include several private hospitals, different in size and geographic location, falling under one management.

We provide an example of two groups under foreign capital which are currently in the region: Elsan, the French group specialized in hospitalization, and the group of testing and treatment centers owned by Alta Semper the English private equity firm providing specialized treatments in Morocco and Egypt. The Ministry of Health announced the privatization of five public hospitals last year (الشارع السياسي /Political Street 2022). There is also a possibility to bring businessmen from the Arab Gulf states to benefit from this project, taking into account the Saudi experience in this field (مجلة الأبحاث2012 الاقتصادية). This program falls under the liberalization of health services by allowing foreign doctors to compete with Egyptian doctors in terms of employment. This is part of the service liberalization plan under the WTO General Agreement on Trade in Services (GATS). Moreover, "mergers and acquisitions in the private health sector increased. This sector has become a magnet of investors from the Arab Gulf due to significant profits and revenues generated by private hospitals. Financial acquisitions in this sector are ranked second among the Egyptian economic sectors."

The same study showed an increased "concern over monopolizing groups in the private medical sector, raising complaints from most Egyptians due to the outrageous increase in service rates, after Emirati group 'Abraaj Capital' acquired a group of major hospitals such as Cleopatra, the Cairo Specialized Hospital, and El Nile Badrawy Hospital, as well as the two largest chains of laboratories in the country: Al Borg (926 branches and 55 biological laboratories) and Al Mokhtabar (826 branches)."

Furthermore, the Saudi Elaj Medical Group acquisitioned 9 major hospitals, the "Cairo Lab" medical laboratories spread across Egypt, and "Techno Scan" radiology centers, which in turn owns 24 branches across different governorates

(العربي الجديد/Al-Araby Al-Jadeed 2022). On the other hand, the Egyptian government resorted to the implementation of health projects under the Private-Public Partnership (PPP) Law. In this context, we cite the alliance between Al-Bareeq for investment and project development, Dar for Construction & Trading (DETAC), Siemens for Medical Devices and Pharmaceuticals, and G4S Facilities Management (English company) to implement and partially manage two projects: the Samouha Hospital for Maternity and Blood Transfusion and the Specialized Mouwasat Hospital (Private Sector Partnership or Public Service Privatization? n.d.).

RELIANCE ON PRIVATE SECTOR TO GUARANTEE THE RIGHT TO HEALTH FOR EVERYONE: THE RISKS

In terms of the health system's response to citizens' expectations, privatization increases discrimination against those who cannot afford private insurance and are, subsequently, not prioritized, as well as health disparity between rural and urban areas. Healthcare coverage is reduced in rural areas, leading to higher infant mortality (كالوتي/Kaloti 2021).

On the other hand, one study shows that service quality indicators are not significantly affected by privatization despite the improved productivity in the Kingdom of Saudi Arabia. In addition, access to healthcare services was reduced due to privatization (Almutairi & Al Shamsi 2018).

In terms of healthcare affordability, privatization promotes the "cream skimming" or "cherry picking" phenomenon. The private health sector essentially (and purposefully) concentrates services on low-cost or low-risk clients, as well as high-value clients, to increase profit. Evidence has shown that privatization increases these practices. People who are disease-free or patients with mild health issues (reduced cost) or are younger are often given priority in the private sector for more profit (Kaloti 2021).

In terms of improving efficiency, Kaloti (2021) notes that excessive diagnosis and treatment are "common in private healthcare systems, often considering patients as revenue sources rather than patients. This leads to ineffective allocation of money and resources. In other parts of the world (India, to be specific), increased privatization led to an excessive use of diagnostic testing, antibiotic prescriptions, and unnecessary surgeries. Doctors tend to service business stakeholders instead of patients, leading to major financial waste" (Kaloti 2021).

TRADE AGREEMENTS AND INTELLECTUAL PROPERTY RIGHTS HINDER THE REALIZATION OF THE RIGHT TO HEALTH FOR EVERYONE

The World Trade Organization (WTO) affects healthcare through two main agreements: the General Agreement on Trade and Services (GATS) and The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). In addition, adopting bilateral or regional trade agreements which include TRIPS-Plus provisions is a real threat for access to treatment for everyone.

THE OUTLINES OF THE GENERAL AGREEMENT ON TRADE AND SERVICES (GATS)

The liberalization of trade and investment which the WTO endeavored to expand and embed exceeds the movement of goods and capital, reaching trade in essential services such as education, health, water and housing, and all others that have a direct effect on health. **Table 6** includes the ratified WTO agreements that directly impact the right to health. These are: the Agreement on the Application of Sanitary and Phytosanitary Measures (directly impacts food safety); the Agreement on Technical Barriers to Trade (impacts the production of pharmaceuticals, biologicals, and foodstuffs); the Agreement on Trade-Related Aspects of Intellectual Property Rights (impacts pharmaceuticals); and the General Agreement on Trade in Services (impacts health services). Services are produced, distributed, promoted, and sold through four means: services crossing international borders, users moving from one state to another, foreign service suppliers entering a certain state to start a business that provides a certain service, and individuals from one member state moving to provide a certain service to another member state. The first means is people moving abroad for consumption (patients moving for treatment or students for education); the second means is professionals moving abroad to provide a service (health professionals); the third means is service providers moving abroad (direct foreign investment in the health sector); and the fourth means is cross-border services (telemedicine: healthcare, diagnosis and treatment, medical education and training, technical expertise in telemedicine).

We would like to note that the liberalization of service trade by the movement of highly-skilled users and professionals will aggravate the shortage of health sector workforce through "brain drain", which will reflect negatively on access to

healthcare in the global south. Moreover, the movement of service providers abroad will deepen inequality in accessing treatment and create a double-standard health system at the expense of vulnerable and destitute social groups.

Table 6. The most significant WTO agreements and their implications for the health sector

Agreement	Health area concerned	Related provisions
Agreement on the Application of Sanitary and Phytosanitary Measures	Food Safety	Stipulates use of Codex Alimentarius standards, guidelines and recommendations as the international reference
Agreement on Technical Barriers to Trade	Production of pharmaceuticals, biologicals, foodstuff	Setting and applying international quality standard
Agreement on Trade-Related Aspects on Intellectual Property Rights	Pharmaceuticals	Patent protection for inventions in all fields of technology
General Agreement on Trade in Services	Health services	Regulation of trade in services

Source: From Kinnon, World Trade, 1998

THE AGREEMENT ON TRADE-RELATED ASPECTS OF INTELLECTUAL PROPERTY RIGHTS (TRIPS)

Signatory states of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) commit to adopting the minimum standards of intellectual property rights while leaving the members the liberty to choose the implementation of the laws that increase protection compared to the text of the agreement, as long as this additional protection does not interfere with the agreement's provisions. The WTO TRIPS, negotiated during the Uruguay Round, incorporated intellectual property rules into the multilateral trade system. TRIPS provisions allow a relative and restrictive flexibility in the drafting of national laws and legislations to ensure an appropriate balance between providing incentives for future inventions in pharmaceuticals and facilitating access to current ones (including but not limited to: the ability to use "flexibility clauses in the agreement" – such as parallel import

and compulsory licenses – allowing low- and middle-income countries to benefit from generic pharmaceuticals, i.e., medication that is the same as a brand-name drug in form, dosage, quality, effect, and purpose. These are produced without a license from the inventor company, with guaranteed quality and at lower cost. However, this experience revealed the disadvantages of TRIPS when applied in Malaysia for instance, as prices of pharmaceuticals increased by a yearly rate of 28% between 1996 and 2005. Also, two billion people are still deprived of basic medication due to the main obstacle of elevated prices (Nations Unies - Haut Commissariat aux Droits de l'Homme 2015).

THE TRIPS-PLUS PROVISIONS AGREEMENT

The United States bypassed the TRIPS agreement under the pretense that it does not provide sufficient protection for American pharmaceutical companies, thus creating the TRIPS-Plus Provisions Agreement, allowing free trade agreements that maximize protection for their benefit. This pertains to adopting stricter intellectual property laws than required in WTO's conditions. Moreover, this agreement aims to limit the ability to use and neutralize flexibility clauses stipulated in TRIPS. Examples include: extending the term and life of a patent,[3] granting patents for new usage or formulas that already exist, and data exclusivity.[4] Rarely do the negotiations of these agreements ensure transparency and stakeholder participation from civil society organizations (CSOs) and social movements that fight for the right to health for everyone, away from trade- and profit-related considerations.

According to the advocates of Big Pharma's hold on intellectual property rights, the prospects of making large profits within temporary monopolies protected against illegal imitation stimulate investment in research and development to innovate new pharmaceuticals and production methods. For this reason, the state must support these companies for high profitability (or "rent" in the economic meaning of the concept) that compensates for the cost of research and development, by enabling them to monopolize the market for a set period of time (at least 20 years). However, studies have shown that TRIPS-Plus standards increase medication prices to hold off or limit competition from generic drugs, thus directly affecting access to medication (تعزيز وحماية حقوق الإنسان / Promoting and Protecting Human rights 2009). Analysis has also shown that there isn't any conclusive evidence that applying TRIPS and TRIPS-Plus in developing countries promoted research

[3] See Definitions
[4] See Definitions

or development of treatment (because having an adequate market is the deciding factor). The claim that protection systems of intellectual property rights are essential for direct foreign investment and the transfer of technology was also proven to be faulty (تقرير ممثل وفد المنظمات غير الحكومية/Report of the Representative of the NGO Delegation 2014).

■ THE IMPACT OF TRIPS-PLUS ON THE REALIZATION OF THE RIGHT TO HEALTH IN THE ARAB REGION

Morocco: Strict laws limiting access to healthcare

In 2004, Morocco and the United States signed a TRIPS-Plus free-trade agreement (FTA) with strict provisions related to intellectual property protection. A comparative study of legal frameworks that guarantee access to medicines (ITPC MENA 2017), including patent laws, pharmaceutical regulations, medicine-related decrees, free-trade agreements, and others, showed the lack of flexibility of these laws in Morocco, compared to Egypt and Tunisia. And thus, the study concluded that: "the provisions in Egypt provide more flexibilities. In Morocco, the conclusion of an FTA with the United States led to the inclusion in the laws of additional constraints. Meanwhile, Tunisia contains some interesting provisions but could better make use of the TRIPS flexibilities, in particular on the grounds to issue compulsory licensing."

Jordan: Monopolization and increase of medicine prices

The Jordan-US FTA signed in October 2000 includes the TRIPS-Plus provisions. The incorporation of these provisions in Jordanian intellectual property laws was a main condition on the US's part for Jordan's adherence to the WTO. However, the constrictive nature of these provisions, particularly those related to the extension of patentability beyond the initial 20 years set by TRIPS and "data exclusivity," negatively affected the right to healthcare. As a result, medicine prices in Jordan registered a 20% increase in 2001. Moreover, the implementation of the data exclusivity condition led to the monopolization of the market to prevent competitors from marketing their products, thus delaying or preventing the availability of generic drugs at a lower cost for citizens (اوكسفام/Oxfam 2007).

Furthermore, no direct foreign investment by foreign pharmaceutical companies relating to the manufacturing of generic medicine in partnership with domestic companies has been registered in Jordan since 2001. The new products that were introduced to the market were only a fraction of the total products introduced to the US and European Union (EU)

markets (اوكسفام/Oxfam 2007).

Deep and Comprehensive Free-Trade Agreements (DCFTA) threatens access to healthcare

The European Union seeks to follow the same US strategy benefitting European Big Pharma through "Deep and Comprehensive FTAs" proposed to Morocco and Tunisia at an initial stage, than Egypt and Jordan within the framework of "Euro-Mediterranean Partnership."

The main lever for trade liberalization in the proposed FTAs is to achieve a kind of convergence at the regulations and legislations level through the gradual incorporation of community acquis (Acquis Communautaire), namely the set of legislations, standards, and regulations forming the EU laws, by the targeted southern Mediterranean countries (Morocco, Tunisia, Egypt, Jordan). This regulatory agreement does not only concern the trade of goods, aiming to ensure the compliance of products with industrial standards, technical specifications, and human and plant health-related measures, but also includes the trade of services, government procurement, competition rules, intellectual property rights, and investor protection.

In this regard, the EU proposes incorporating TRIPS-Plus provisions into the health standards stipulated by domestic laws in Tunisia and Morocco (especially the extension of patentability and data exclusivity). This measure will make access to healthcare even more challenging for middle- to low-income social groups. In Tunisia for instance, where generic drugs production covers 70% of the demand, extending patentability beyond the initial 20 years stipulated by WTO's TRIPS-Plus would deprive the Tunisian pharmaceutical industry from producing generic drugs that could replace European pharmaceuticals for the new generation (Haddad 2019).

Pharmaceutical sector professionals in Tunisia confirm that major European companies are ready to use all means necessary to extend patentability to 40 or 50 years compared to the current 20 years. As such, if Tunisia agrees to the EU-proposed DCFTA, the cost of healthcare for Tunisians will increase and the survival of the domestic pharmaceutical industry will be threatened.

CONCLUSION

This report addressed the effects of neoliberal globalization on human rights, particularly the right to health. It demonstrated the key role of international financial institutions (IFIs) in disseminating neoliberal policies that are based on economy liberalization – privatization – macroeconomic balances prioritization through structural adjustment programs (SAPs), taking advantage of the debt crisis in the global south. The mechanisms used by neoliberal economic policies to impact the right to health, be it directly or through their repercussions on social determinants of the right to health, were analyzed. The negative effects of neoliberal globalization on the right to health in the Arab region were highlighted by demonstrating the negative outcomes of public spending austerity measures, then privatization policies, and finally free-trade agreements (FTAs).

On the one hand, austerity measures in middle-income Arab States led to a significant decrease of growth rates in "total health expenditure per capita", to varying degrees across Arab States post-Arab Spring, and burdening citizens with a larger share of medical and treatment expenses. Public health sector employment also decreased and pressure was exerted on the wages of the sector's workforce. Lastly, pressure on public expenditure negatively affected investment endeavors in the health sector, especially in hospitals and primary healthcare units.

On the other hand, privatization gave a strong push to the private health sector, allowing foreign capital to provide an array of health services. This aggravated the risks of health financialization in Arab States and limited the access of vulnerable groups to the right to health.

Finally, contrary to the promises made by multilateral financial and trade organizations to encourage investment and innovation, signing trade agreements that include the protection of intellectual property rights, particularly TRIPS-Plus provisions, reinforced market monopolization by European and American pharmaceutical companies and prevented Arab States from benefiting from the production of generic drugs, particularly in Jordan and Morocco.

DEFINITIONS

A patent: gives the owner of the invention the legal right to exclude others from making, using, or selling an invention for a limited period of time. It may be granted for the invention of a certain product or process.

Data exclusivity: gives the inventor the right to prevent third parties from using data presented by the inventor to the regulatory committee to receive a marketing license for the pharmaceutical product for a set period of time.

Compulsory licensing: a license to use a patented invention issued by the state at the request of a third party. It is considered one of the flexibility aspects provided by the WTO through TRIPS.

Parallel import: buying a patented medicine from a legitimate source in an exporting country and importing it without the approval of the "parallel" patent holder in the importing country.

Linkage between patent and marketing authorization: a link between the granting of marketing approval and patent protection. The marketing of a generic version of a medicine could only take place once the patent protection is over.

Experimental use – Bolar provision: it is possible to allow the experimental use of an invention under patent protection as it does not violate the patent nor the protected market. Certain states allow the experimental use of the patented drug, including clinical trials and experimentation, to certify the effectiveness of the generic product so that it can be put on the market once the patent protection period expires.

Note: These definitions are extracted from ITPC MENA, Assessment of national intellectual property landscapes and their impact on access to medicines, September 2017.

REFERENCES

- Alami, R. 2022. "Towards A 'New Normal' in Health Policies in The Arab Countries." Economic Research Forum (ERF). Link.
- Almutairi, A.G., & Al Shamsi, H., 2018. "Healthcare System Accessibility in the Face of Increasing Privatisation in Saudi Arabia: Lessons from Australia." Global Journal of Health Sciences, 10(7): 111-121. Link.
- André, C., Batifoulier, P., & Jansen-Ferreira, M. 2016. "Privatisation de la Santé en Europe. Un Outil de Classification des Réformes." CEPN, Document de travail, 2015-02. Link.
- Balakrishnan, R., & Elson, D. 2011. "Introduction: Economic Policies and Human Rights Obligations." Radhika Balakrishnan and Diane Elson, Economic Policy and Human Rights: Holding Governments to Account. London: Zed Books.
- Bohoslavsky, J. P., & U.N. Secretary-General. 2015. "Effects of Foreign Debt and other related International Financial Obligations of States on the Full Enjoyment of all Human Rights, particularly Economic, Social and Cultural Rights: note/by the Secretary-General." Link.
- Chesnais, F. (1997). "La Mondialisation du Capital."
- Haddad, M. 2019. "En Tunisie, un Accord avec l'UE Menace de Faire Flamber les Prix des Medicaments." Le Monde. Link.
- Harding, A., & Preker, A. S. (Eds.). 2003. "Private Participation in Health Services (Vol. 434)." World Bank Publications.
- International Labour Organization (ILO). 2020. "Global Wage Report 2020-2021, Wages and Minimum Wages in Times of COVID." Link.
- ITPC MENA. 2017. "Assessment of National Intellectual Property Landscapes and their Impact on Access to Medicines."
- Jacques, O., & Noel, A. 2022. "Austerity Reduces Public Health Investment (No. 2022s-02)." CIRANO – Working report.
- Kentikelenis, A. E. 2017. "Structural Adjustment and Health: A Conceptual Framework and Evidence on Pathways." Social Science & Medicine, 187: 296-305.
- Kinnon, C. M. 1998. "World Trade: Bringing Health into the Picture." In World Health Forum, 19(4): 397-406.
- Nations Unies - Haut Commissariat aux Droits de l'Homme. 2015. "L'accès aux Médicaments et Droit à la Santé." Link.

- Organisation for Economic Co-operation and Development (OECD). 2020. "Mobilizing Tax Revenues to Finance the Health System in Morocco." Link.
- OIT. 2022. "Garantir un Travail Décentau Personnel Infirmier et aux Travailleurs Domestique Acteurs Clés de l'économie du Soin à Autrui." Conférence Internationale du Travail110ème session.
- Organisation Mondiale de la Santé (OMS). 2020. "La Situation du Personnel Infirmier dans le Monde 2020: Investir dans la Formation, l'emploi et le Leadership." Link.
- Ortiz, I., Cummins, M., Capaldo, J., & Karunanethy, K. 2015. "The Decade of Adjustment: A Review of Austerity Trends 2010-2020 in 187 Countries." Working Report No. 53, South Center Initiative for Policy dialogue, Columbia University. Link.
- Ortiz, I., & Cummins, M. 2013. "The Age of Austerity: A Review of Public Expenditures and Adjustment Measures in 181 countries." Working Report, South Center Initiative for Policy dialogue, Columbia University. Link.
- Petras J., & Veltmeyer, H. 2001. "Globalization Unmasked: Imperialism in the 21st Century." Fernwood Publishing.
- Stiglitz, J., & Pike, R. M. 2004. "Globalization and its Discontents." Canadian Journal of Sociology, 29(2), 321.
- Stubbs, T., & Kentikelenis, A. 2017. "International Financial Institutions and Human Rights: Implications for Public Health." Public Health Reviews, 38(1): 1-17.
- World Health Organization (WHO) EMRO. 2023. "Core Health Indicators." Link.
- WHO, SDG indicator metadata 2021-12-2020
- World Health Organization (WHO) EMRO. 2014. "Analysis of the private health sector in countries of the Eastern Mediterranean: Exploring Unfamiliar Territory." Link.
- World Bank. 2023. World Development Indicators. Link.

- اوكسفام، الكلفة عالية وليس هنالك من فوائد تذكر، 2007
- تعزيز وحماية حقوق الإنسان المدنية والسياسية والاقتصادية والاجتماعية والثقافية، بما في ذلك الحق في التنمية، تقرير المقرر الخاص المعني بحق كل إنسان في التمتع بأعلى مستوى ممكن من الصحة البدنية والعقلية، أناندغروفر، الأمم المتحدة، مجلس حقوق الانسان، مارس 2009
- تقرير ممثل وفد المنظمات غير الحكومية مجلس تنسيق برنامج الأمم المتحدة المشترك

المعني بفيروس نقص المناعة

- البشري/الإيدز،11-9 كانون أول/ ديسمبر 2014
- تقييم واقع الملكية الفكرية وتأثيرها على الوصول إلى الأدوية في كل من المغرب وتونس ومصر، شتنبر2017 ITPC – MENA
- محمود عبد الفضيل، سياسات التنمية الاقتصادية والاجتماعية في المنطقة العربية رؤية للمستقبل، دار العين للنشر،2012
- محمد سعيد السعدي، أوهام النيوليبرالية في المنطقة العربية، منشورات شبكة المنظمات العربية غير الحكومية للتنمية، بيروت، 2022
- منظمة الصحة العالمية، المكتب الإقليمي لشرق المتوسط، المشاركة مع القطاع الخاص للنهوض بالتغطية الصحية الشاملة، 2018
- العربي الجديد، مصر تبيع 5 من اكبر مستشفياتها العامة....وقفزة في مصاريف العلاج، العربي الجديد، 17 سبتمبر 2022
- مجلة الأبحاث الاقتصادية، خصخصة مستشفيات القطاع العام وأثرها على تحسين جودة الخدمات الطبية من وجهة نظر العاملين والمرضى المراجعين، دراسة تطبيقية على مستشفيات القطاع العام العاملة في مدينة جدة، مجلة الأبحاث الاقتصادية لجامعة سعد دحلب البليدة العدد، 07 ديسمبر2012. الرابط.
- العولمة وبدائلها: لقاء مع سمير أمين، موقع "تريكونتينونطال،29 اكتوبر، 2018
- آثار سياسات التكيف الهيكلي على التمتع الكامل بحقوق الانسان، تقرير مقدم من الخبير المستقل السيد فانتوشيرو وفقا، 1999
- لمقرري اللجنة 102/1999 و103/1997، الأمم المتحدة، لجنة حقوق الانسان،24 فبراير 1999
- رشا كالوتي، خصخصة الرعاية الصحية: عقبة في طريق تحقيق التغطية الصحية الشاملة، إمباكت إنترناشونال، 29 ابريل 2021
- الشارع السياسي (Political Street)، خصخصة مستشفيات المؤسسة العلاجية بمصر.. التداعيات المحتملة، موقع التخطيط السياسي سبتمبر 30، 2022. الرابط.
- وكالة المغرب العربي الأنباء، رأي مجلس المنافسة حول وضعية المنافسة داخل السوق الوطنية للرعاية الطبية المقدمة من لدن المصحات الخاصة والمؤسسات المماثلة لها، 2022. الرابط.
- سها بيومي، الصحة والعدالة في مصر: نحو منظور الانصاف الصحي، التقرير العالمي للعلوم الاجتماعية، منشورات اليونسكو، باريس، 2016
- منظمة الصحة العالمية، المحددات الاجتماعية للصحة، تقرير الأمين العام، يناير 2021
- اليوم 24، وزير الصحة يقول إن المغرب تلزمه 25 سنة لسد خصاص الموظفين بالمستشفيات، موقع اليوم 24، 27 دجنبر، 2020

annd
Arab NGO Network for Development
شبكة المنظمات العربية غير الحكومية للتنمية

AMERICAN UNIVERSITY OF BEIRUT
FACULTY OF HEALTH SCIENCES

The Arab NGO Network for Development

works in 12 Arab countries, with 9 national networks (with an extended membership of 250 CSOs from different backgrounds) and 25 NGO members.

P.O.Box Mazraa 5792/14 Beirut, Lebanon

The Faculty of Health Sciences at the American University of Beirut

aims since its inception to shape the public health discourse by preparing professionals to be agents of change, and producing research that impacts practice and policy, and thus the health of populations.

American University of Beirut
P.O.Box 11-0236 / Faculty of Health Sciences
Riad El-Solh / Beirut 1107 2020
Lebanon