Trading in Healthcare Services in Kenya, are we prepared?

Case study on the implications of committing healthcare services in Kenya under GATS

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Abbreviations

AIDS - Acquired immuno-deficiency syndrome
CESCR - The International Covenant on Economic, Social and Cultural Rights
C.I.N. – Consumer Information Network
FDI – Foreign Direct Investment
GATS– General Agreement on Trade in Services
G.D.P. – Gross Domestic Product
HIV- Human immunodeficiency virus
H.M.O.'s – Health Maintenance Organisations
I.M.F. – International Monetary Fund
N.G.O. – Non-Governmental Organisation
S.A.P.'s – Structural Adjustment Programmes
SOMO - Centre for Research on Multinational Corporations, Amsterdam
UN- United Nations
UNICEF- United Nations Children's Education Fund
WEMOS – Foundation for the promotion of health for all, Amsterdam
W.H.O. – World Health Organisation
WTO – World Trade Organisation

Introduction

The World Trade Organisation [**WTO**] deals with rules governing trade among its 144 members. It has binding trade agreements[2] that members' states have agreed to comply with in their relationship with one another. A trade agreement, for example, by the name of **General Agreement on Trade in Services**[3] [**GATS**] deals purely with trade in services sector. This is just one amongst many other WTO's trade agreements such as those that deal with Agriculture, intellectual property rights, etc.

GATS has a potential of far reaching consequences on the citizens of the world since it incorporates and brings to the fore areas that were never thought before as tradable (i.e. health, water, educational services) and hence to be under the dictates of the WTO rules and system. Some of these basic services are within the realms of government control, management, and support. Governments globally and more so those of developing countries, literally provide the services, e.g. healthcare services in Kenya have been for a long time a major responsibility of the government.

The agreement covers nearly all-imaginable services. Services were deemed then, and even today, to play a pivotal role in global trade. That's why they were incorporated in the global trading system. According to the WTO, services sector covers well over **60%** of world G.D.P., hence regarded as the main creator of job opportunities in both developing and developed countries.

It was important therefore to bring rules to govern services all over the world. That's how essentially GATS came to existence. But that's not the complete story; other strong pushers for services agreement within WTO included multinational firms such as ***American express, Citi corp***[4] etc***.***

The agreement categorizes four trading modes for services i.e.,

- Services conducted through **cross border supply**[5] [normally referred to as ***mode one***]. A good example is the use of advice services over the telephone from one country to another. For example, a patient would be residing in the country and receiving instructions from medical practitioners in a faraway country like Canada (this is normally referred to as **telemedicine**.)

- Services offered through **consumption abroad**[6]. [***mode two***]. For example, a Kenyan patient leaving the country for treatment in another country, say like the United Kingdom.

- Services offered through **commercial presence**[7] [***mode three***].
  What this means is that firms can legally establish branches, subsidiaries or joint ventures and offer trade services in other countries that are Member States of the WTO.

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[1] This Covenant was adopted and opened for signature, ratification and accession by General Assembly Resolution 2200 A (XXI) of 16 December 1966.
Entry into Force: 3 January 1976, in accordance with article 27.

[2] At the end of the Uruguay Round of multilateral trade negotiations in 1994, the WTO came up with a package of over 40 agreements and interpretive Understanding and decisions. See this at the web <http://www.wto.org/english/docs_e/legal_e.htm>

[3] Visit: http://www.wto.org/english/tratop_e/serv_e/gatsintr_e.htm

[4] Speech by David Hartridge, the Director of Trade in Services Division, entitled " What the General Agreement on trade in Services Can do". This was during a conference in London on 8th January 1997 on the theme 'Opening markets for banking worldwide: the WTO General Agreement on Trade in Services'

See also World Development Movement Publication, "In whose service"

[5] GATS Article I.2a.

[6] GATS Article I.2b

[7] Ibid. Article I.2c

A company establishing a hospital or an insurance firm in another country to offer services there is a good example.

- Services offered through the "**presence of natural persons" in another country[8].** [***mode four***]. This is when medical practitioners, i.e. gynaecologists or dentists or even nurses leave the country to go to, say, Botswana or elsewhere to offer their professional services there.

All services supply process are categorized under the four modes. Indeed, all the services one can imagine are captured in the four aspects of delivery outlined above. The GATS agreement lists 11 categories of services[9], thus **Business**, **Communication**, **Construction and Engineering**, **Distribution**, **Education**, **Environment**, **Financial**, ***Health***, **Tourism and Travel**, **Recreational**, **Cultural and Sporting**, **Transport and "Others".** All this sectors can be broken down further into sub sectors, which are very divers in scope. In *healthcare* services we can have such sub sectors as "the general and specialised services of medical doctors, deliveries and related services, nursing services, physiotherapeutic and paramedical services, all hospital services, ambulance services, residential health facilities services and services provided by medical and dental laboratories"[10].

Education, health, or water services are vital services that have long been left to the domain of government control. Basic human rights that include access to these services, for instance, are even enshrined in government contracts with their citizens. They legitimised many a government existence. The constitutions of many developing countries contain sections that allude to the governments being responsible for the provision and regulation of these basic human necessities. For example, after attaining our independence in 1963 the government of Kenya promised to fight three great enemies, that is *ignorance*, *disease*, and *poverty*. By fighting in this context, what the government meant was that it would try its best to bring to an end these great enemies. It took upon its shoulders the responsibility to ensure that we are *healthy* as citizens, that it will provide education, clean water etc. this was well articulated in government documents then[11]. The constitution (and even the proposed[12] new one) has sections that allude to the state being responsible for ensuring that health to all is achieved. [See section 2.1.] It never shifted this task to foreign service providers through their commercial presence here.

This study dealt with ***mode three*** aspect of service in healthcare services only. Since it was impossible to deal with that mode in isolation as it influences negatively/positively on Kenya and probably other economies in the developing world, the GATS agreement was, as a whole, studied and where necessary quoted.

An other task of the study was to see whether the agreement impacts negatively on the right to health as espoused by other international covenants that deal with human rights issues. The

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[8] GATS Article I.2d

[9] See also "An Introduction to the GATS" WTO Secretariat Trade in Services Division, October 1999. it is important to note that during the GATS negotiations that started since 2000, categories are being redefined and new categories have been added.

[10] *International trade in health services, a development perspective.* UNCTAD/WHO 1998. GATS COMMITMENTS IN THE HEALTH CARE SERVICES SECTOR AND THE SCOPE FOR FUTURE NEGOTIATIONS. By Jolita and David.

[11] Sessional paper No. 10 of 1965 on African Socialism and its Application to Planning in Kenya, is good example

[12] At this period of time in the Kenya history, the constitution is being reviewed to accommodate the changing times and to ensure that Kenya adjust to global trends, politically economically and socially. Section 30 (1) of the draft Kenya constitution says,

"The state shall observe, respect, protect, promote and fulfil the rights and freedoms in this Bill of rights"

One of the rights in the Bill of rights is spelt out in section 57

(1) Every person has the right to health, which includes the right to healthcare services, including reproductive healthcare.

(2) No person may be refused emergency medical treatment.

For more details visit http: //www.kenyaconstitution.org.ke.

study looked at the **Covenant of Economic, Social and Cultural Rights**, specifically **article 12**[13], which is an obligation to all governments. Will the citizens of the developing countries in particular, be able to access to traded health care services if they do not have the *means* of doing so? How will the foreign investors using **mode three** reconcile their primary desire to make acceptable returns and besides profits on one hand and the obligation to offer health services to the poor on the other hand in the developing countries? Will there be no conflict of interest as to what role the foreign healthcare service provider has in the developing countries, if particularly it's practises are in conflict with government objectives? How do Foreign Service providers in the healthcare services sector, undermine the achievement of ***article 12***[14] of the International Convention of Economic, Social and Cultural Rights? Will healthcare services be traded in total disregard of trampling on human rights obligations? Is health not a human right?
The third and final aspect of the study was to see if possible Kenya's commitments in the trade in health care services within the WTO would hinder or promote its primary objective to "promote and improve health status of all Kenyans"[15] and in tandem with that to see whether healthcare services are "more effective, accessible and affordable"[16] as a result**.**

0.1 Some background Information about Kenya

Kenya has approximately 580 thousand square kilometres of land and with a population of approximately 30.4 million[18] inhabitants. It got her independence from the British in 1963. It immediately adopted a capitalist economic system combined with socialist ideas. This is what it called African Socialism[19]. Whereas it encouraged market oriented economy it nevertheless involved itself directly in many sectors of the economy to guarantee the social security of its citizens.
It is regarded as a low-income group country [World Bank 2000 criteria]. The proportion of health budget to G.D.P. is **4.6%** [WHO 2000]. Life expectancy at birth is **47**.**3** years for males and **48.1** years for females.
"Health expenditure in the rural areas account for **30%** while urban areas [where only **20%** of the population live] account for **70%** of the health expenditure [See also section 2.3]. There is only one doctor for every **33,000** of rural population compared to one doctor for every **1,700** urban residents"[20].

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[13] Article 12

1. 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.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
   (a) The provision for the reduction of the stillbirth-rate and for the healthy development of the child;
   (b) The improvement of all aspects of environmental and industrial hygiene;
   (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
   (d) The creation of condition which would assure to all medical attention in the event of sickness.

[14] Ibid.
[15] The National Health Sector Strategic Plan: 1999- 2004, Chapter 2.3
[16] Ibid.
[17] This was in line with article x of the Alma-Ata Declaration of September 1978. 138 member countries in association with WHO and UNICEF adopted the declaration in the then Kazakh Soviet Socialist Republic (now Kazakhstan)
[18] Section 5.4.2 of National Development Plan 2002-2008
[19] This is well expounded in the Sessional paper No. 10 of 1965 on African Socialism and its Application to Planning in Kenya. Government of Kenya document.
[20] Kenya's National Development Plan 2002-2008 Chapter 5, Section 5.2.3
[21] These documents include Economic Surveys, Poverty Reduction Strategy Papers, Development Plans, etc.

CHAPTER ONE
GATS AND KENYA'S COMMITMENT

1.0 About GATS

As mentioned earlier in the introduction, the General Agreement on Trade in Services[22], GATS, is one of the most far-reaching achievements of the *Uruguay Round*[23]. For the first time the global community was having the first and only multilateral legal (enforceable) frame work that provided for a set of rules governing international trade in services.
As commitments are made to liberalise services[24] across the board, Members of the WTO are obliged to adhere to the basic guiding principles that govern the agreement.

1.1 Basic obligations

These include one, the *General obligations* which in principle applies to all members directly and automatically whether they have committed themselves to liberalise any services sector or not. This principle incorporates the *horizontal* rules mentioned below, that is [a) and b)], which covers **all** government measures that affect trade in services.
The second series of obligations apply when a Member *commits itself to liberalise specific service sectors* of its choice, to which the principles of **market access** and **national treatment** immediately takes effect.

Lets explain the principles thus,

General Obligations;

a) The Most Favoured Nation principle[25]. (MFN).
Favour one favour all. Members are obliged to extend "treatment no less favourable than that accorded to like services and services suppliers of any other country"[26]. For example, if a foreign health services provide operates in Kenya under any of the modes of services supply, Kenyan authority is supposed to treat on equal terms and conditions this foreign service provider as any other country' service provider that has entered Kenya.

b) **Transparency**[27].
Members are required to publish all new laws relating to the services sector and to establish national enquiry points that will give all information, i.e. about laws, regulations[28], etc., requested by any other WTO member regarding measures which affect the general application of the GATS agreement. This was to be done within two years from the time GATS came into force i.e. by the end of 1997.

Specific commitments;

c) **The National Treatment principle**[29].
Once Kenya has made a certain specific commitment to liberalise on the various service sectors it has to treat equally the foreign service provider as its very own service providers.

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[22] It is a WTO legal document divided in six parts with a total of 29 articles. It is supplemented by annexes and schedules which all have a legal bearing.
[23] Multilateral trade negotiations launched at Punta del Este, Uruguay in September 1986 and concluded in Geneva in December 1993. Signed by Ministers in Marrakesh, Morocco, in April, 1994
[2424] GATS article xix. 1
[25] GATS article ii
[26] General Agreement on Trade in Services [GATS], article ii.1
[27] GATS article iii
[28] Any change of regulation that applies to any of the services that come under specific commitments must be notified to the WTO
[29] GATS *Part 3 –Specific commitments* -Article XVII

d) **Market access**[30].
Simply put, this is the legal right of service provider to supply his/her service through any of the four modes of supply as agreed in the schedule of the country's commitments (which might contain limitations), and not to be hindered by specific government measures, such as limitations on the number of service suppliers.

Having clarified the above point (d) thus, the government has to check whether or not to put up "measures"[31] that will **regulate** the committed services sectors in the country's schedule. The agreement recognises "the right of members to regulate"[32] as long such "measures" are done in "a reasonable, objective and impartial manner"[33]. Further, the Doha Ministerial declaration reaffirms that members have the right "to regulate, and to introduce new regulations on, the supply of services"[34]. However, this legal document [GATS] is not clear on this matter since such "measures" must "not constitute unnecessary barriers to trade in services"[35]. What constitutes as "unnecessary barrier to trade" may be interpreted in different shades by different entities. *See also* section 4.2 a, *for further elaboration and digression on the regulation.*

1.2 Further liberalisation under GATS

Even those *developing* countries that were opposed[36] to the introduction of the services within the WTO framework now have to comply with what had been agreed upon. This is mandatory for all WTO members since all agreements are binding to all members.
Countries were to commit themselves "with a view to achieving a progressively higher level of liberalisation"[37] in the *specific service sectors* that they felt they had comparative advantage over the others.
The liberalisation process is being continued with new negotiations to let loose services sectors to market forces began from 1st January 2000. In order to advance the GATS negotiation programme, the 2001 Doha Ministerial Declaration article **15** states that Member States

> " shall submit initial **requests** for specific commitments by 30 June 2002 and **offers** by 31 March 2003"[38](emphasis is mine).

The initial requests will be on **bilateral** basis since countries will be targeting those services sectors in *specific countries* and which if granted to them will translate into maximum advantage to their own service providers. By the time of writing this paper, many countries would have received these requests by 30th June 2002. They will have to react by making an "offers" list by 31st march 2003. From that date until the year 2005 WTO members will have to negotiate what service sectors they will commit themselves to open up under GATS. This will subsequently mean, countries may have to literally overhaul their specific schedule of commitments as they stand now i.e. by to attaching conditions, measures, rules, regulations, and probably changing of domestic laws, etc in order to accommodate the new players in the new market scenario. No country thereby, would want to respond positively to these 'requests' without receiving 'credit' from the WTO members.

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30 GATS *Part 3* - Article XVI
31 Measures means "any measure by a member, whether in the form of a law, regulation, rule, procedure, decision, administrative action, or any other form" see GATS Article XXVIII.a
32 See the GATS preamble, the fourth verse. Visit http://www.wto.org/english/tratop_e/serv_e/gatsintr_e.htm
33 GATS article vi: clause 1
34 WTO Ministerial Declaration document WT/MIN (01) DEC/1
35 GATS article vi.4
36 'A number of developing countries, led by India, and Brazil of the G10 developing countries (Argentina, Brazil, Cuba, Egypt, India, Nicaragua, Nigeria, Peru, Tanzania, and Yugoslavia), flatly opposed putting services on the Uruguay Round Agenda'. See Chapter 3 of "Unpacking the GATT" by Phillip Evans
37 WTO'S GATSPart 4 Article 19.1
38 See WTO Document, Ministerial Declaration WT/MIN (01) DEC/W1

Quite a number of government officials have had the perception that, when it comes to **requests,** what matters most is merely to identify the markets for its citizens or their service providers. They do not bear in mind that those countries receiving the requests might ask them to likewise open up those same service sectors they are requesting others to open up. WTO Members, which are willing to open up the requested sectors, will have to open up those same service areas to all WTO members in complying with the most favoured principle [MFN][39]. This will mean changing their current schedule of commitments to add the new commitments. In so doing the granting nations would not want a scenario were they are denied market access to services sectors they have granted to others. There are those who argue that the market access negotiations under GATS does not impose the reciprocity principle, but it is obvious it might be difficult to tell others to open up certain service sectors and close your door to others who want to venture to your market on the same service sectors. Kenyan officials may, for instance, fail on this test since the burning issue as of now is how to venture out to those lucrative markets in Europe, U.S.A. and South Africa, etc, for our unemployed *nurses* and other *health professionals.* *See also appendix I, which gives a quick glimpse of where the efforts of the government are directed. Emphasis is mode four and three when it comes to market access requests.*

1.3 Relevance of service sector in Kenya

The relevance of service sector in Kenya cannot be gainsaid. It contributes significantly to the Kenyan national G.D.P. For example in **1998** it contributed approximately **54**%[40]. This is mainly from the *tourism* sector. Actually, the period before that, tourism used to be the leading income earner for the Kenyan economy. The relevance of service industry to Kenya's economy cannot be down played. It is equally important globally. Therefore, it was seen to be prudent to even further commit services sectors to further and "higher level of liberalisation" to spur growth of the economy. This was done under the WTO commitments on GATS in 1994.

1.4 Kenya's Specific Commitments

It's important to clarify what *specific commitments* means under the GATS agreement. Specific commitments are normally contained in a country's service schedule that forms part of the GATS agreement [41]. This schedule contains a list of service sectors and sub sectors that a country undertakes to open up for foreign suppliers (to liberalise) and to provide **market access** and **national treatment** on the terms and conditions specified in the schedule. When Kenya makes any specific commitment, for instance, it binds itself to permanently treat suppliers of the services listed therein under the terms and conditions clearly outlined in the schedule and according to the GATS rules. Under the WTO/GATS rules, if Kenya intends to "modify or withdraw any commitment in its schedule"[42] this can only be done after "reaching agreement on any compensatory adjustments"[43] with the affected parties or countries and only after the agreement has been in force for **three** years. The "compensatory adjustments shall be made on the most-favoured-nation basis"[44], hence making it practically impossible for a developing country like Kenya to withdraw any commitment once in its schedule of commitments even when it is obviously necessary because of the costs involved. See also section 4.1

Kenya's commitment to the GATS agreement is not very wide as *may* be with other developed countries. Kenya like many of the developing countries opted only to take advantage of the agreement by opening up to service sectors that it felt it may get good returns, hence not very wide scope.

It went for some minimal commitments such as in the following services sectors

- **Tourism** [hotels and restaurants, including catering- 641-643],

[39] GATS article ii.1
[40] WTO Secretariat Kenya Trade Policy Review-2000
[41] GATS article xx.1
[42] GATS Article xxi.1 (a)
[43] Ibid. Article xxi. 2(a)
[44] Ibid Article xxi. 2(b)

- **Financial** [this covers insurance and insurance- related services-812, banking and financial services],
- **Transportation** [air transport services: maintenance and repair of aircraft-8868, selling and marketing of air transport services, computer reservations systems, road transportation: maintenance and repair of road transport equipment- 6112+8867, passenger transportation 7121+7122],
- **Communication**.

The above list is not inclusive of all the extent of the commitments made. It is only meant to show the services sectors in general that the country had commitments. This was done in **1994** under the Kenya schedule of commitments at the end of the Uruguay Round negotiations.

It is important to note here that behind what appears to be voluntary opening up of the various services sectors to the market forces, pressure from global lending institutions such as **I.M.F** and **World Bank** has had an upper hand. Actually, some of these targeted sectors were areas that Kenya had to liberalise and open up for foreign competition if it were to receive loans for development purposes[45]. Hitherto, the relentless insistence of the two lending institutions is that the government has to surrender the role it plays in **Telkom Kenya**[46] and hence sell its shares to private investors. These were typical conditionalities given to developing countries under the infamous Structural Adjustment Programmes [S.A.P.'s].
Therefore, before the actual commitment to the WTO's GATS agreement, Kenya had already gone an extra mileage in liberalisation processes in the service industries in the 1980's and early1990's[47]. The difference with GATS however is, commitments in GATS are binding, i.e. are permanent and difficult to reverse.

Lets have a look at some of the services sectors (sub-sectors) committed that have a direct link to healthcare service provision.

a. Health insurance

In the insurance service sector, the government made commitments in all the sub sectors in that category in their **1994** schedule of commitments. In the sub sectors **life, accident and health insurance services**- ***8121*** for instance, mode one, two, and four were unbound[48]. In **non-life insurance services**- ***8129*** the *mode one*, and *four* were unbound. Kenya can thus introduce new restrictions or measures on those modes. In **mode three** and specifically on life insurance the country put a condition for foreign commercial presence that they have to put one third of Kenyan nationals ownership of paid-up capital. This was meant to encourage involvement of local expertise on the business, and to ensure benefits are shared with the hosting country.
Very few firms offer specialised services in one form only. For example, those firms that offer life insurance cover may also be engaged in offering non-life insurance cover.
It is only of late that we are seeing an increase of firms that operate health insurance only, particularly after the government introduced the concept of **cost sharing** (see section 2.3) within the government healthcare system. Quite a number of Kenyans are increasingly opting to take health insurance cover, particularly with the health management organisations [HMO's,] instead of paying directly to the hospitals. It is much more convenient.
Since Kenya had already set the financial sector as one area that it could open up for liberalisation, insurance firms dealing with life, health and all other forms of insurance fell under that category. No much thought was given on what type of insurance would serve what type of national interests.

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[45] The General Agreement on Trade in Services- An impact Assessment by Consumers International
[46] The main shareholder in the Telkom Kenya Company is the government. This means it has lots of influence on how the company is run and on its policy in operations.
[47] Impact assessment by Consumers International, The General Agreement on Trade in Services 2001
[48] The term "Unbound" when appearing in a country's schedule means that new measures regulating the service in that specific mode can always be introduced.

i. Kenyans with health insurance cover

Approximately **300,000** Kenyans have health insurance cover with private firms either through their employers or individual initiatives. This accumulates to an estimated premium income of approximately Kshs 3 billion[49]**.** That figure is approximately about one percent of the Kenyan population, implying that a huge segment of Kenyans are still not covered hence the burden of paying hospital bills lies with themselves or through fundraising. The national and foreign health insurance firms[50] or even the health maintenance organisations [H.M.O.'s] are mostly located in the lucrative urban areas hence leaving the other population in the rural areas uninsured. The main reason advanced for the biases towards serving the urbanites is that investors are purely driven by profit motive hence, that's where they can reap good returns for their investments since the rural populace is poor[51].

The health insurance firms and the H.M.O.'s play a complimentary role in the healthcare service in the country. The latter's status[52] is confusing, since they are neither registered by the Commission of Insurance[53] nor are they purely healthcare providers. Their role nevertheless has been vital in providing Kenyans- at least those who can afford- of the middle class and some in the lower class cadre with healthcare services. "Some of these organisations have established medical facilities, that is, fully equipped clinics manned by doctors and nurses, offering outpatient treatment. Others have contracted hospitals for inpatient and outpatient treatment"[54]. When you pay insurance premiums to the H.M.O.'s and you become an in/out patient[55] in any of their recognised hospitals/clinics, they will pay directly to the hospital/clinic and reclaim money from the main insurance companies who are the *main* risk underwriters. When you are insured through the main insurance companies, and you happen to be hospitalised, you will have to pay directly to the hospital and claim reimbursement later from the same.

ii. Plans to ensure insurance cover for all citizens

The government has stated numerous times its intentions that all the citizens obtain health insurance cover. It has committed itself to reform the health insurance sector "through the development of innovative financing mechanisms that guarantee the accessibility of basic packages of health services to all, based on need and not ability to pay"[56]**.** Though this is not the policy statement, nevertheless it gives insight into the thinking of the government as regards health insurance. The step towards realization of this goal was the creation of the National Hospital Insurance Fund [NHIF] established in 1966 under the National Health Insurance Fund Act. The government recently sent teams to Europe to study how public insurance is rationalized there. Currently this statutory government body covers only approximately 2 million Kenyans. Its members contribute between Kshs. 30 [US cents 40] and Kshs. 320 [US $ 4.10] per month and

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49 Statistics and information obtained from Kenya's Commissioner of Insurance.

50 Major insurance firms in Kenya that deal with health insurance include the following; America Life Insurance [ALICO], Jubilee Insurance, Madison Insurance, Insurance Company of East Africa [I.C.E. A.], etc. See table 3b.

51 More than half of the population of Kenya are poor meaning they live below the poverty line that is one dollar a day or less, according to Kenya's Poverty reduction strategy paper, for the period 2001 –2004 Chapter 3.

52 'The H.M.O.'s are not Insurance Companies and therefore are not licensed to carry risks. Their responsibility ends after passing the risk to Insurance Companies'- Statement made by Sammy Makove, Commissioner of Insurance on Friday 19th July 2002 in his presentation at an Experts meeting on "GATS and Healthcare services in Kenya" organised by Consumer Information Network at Silver Springs Hotel.

53 The commission of insurance in Kenya acts as a regulator in the entire insurance sector.

54 Information derived from Sammy Makove, Commissioner of Insurance on Friday 19th July 2002 in his presentation at an Experts meeting on "GATS and Healthcare services in Kenya" organised by Consumer Information Network at Silver Springs Hotel.

55 In-patient here means a person who formally gets admitted to a hospital and gets medical attention throughout his stay there. Out patient are persons who visit the health facility and are released immediately without spending the night in the hospitals. Mostly they come for minor ailments.

56 National Development Plan 1997-2001- Section 6.8.16

they get rebates of approximately Kshs 400 [US $ 5] and Kshs 2000 [US $ 25] per day[57]. The NHIF is the preferred choice of many of the poor in the country because of primarily its low insurance premiums, vis-à-vis their social status. Because of financing "partial in-patient care services for its members"[58] as opposed to clearing the entire hospital bills, "the cumbersome claim procedures associated with reimbursements"[59] and its linkage with poorly managed government hospitals has been a deterrent to those who would even wish to join its membership. That is one reason why people are preferring private insurer as opposed to the government owned insurance body, inspite of the biting poverty in their midst.

iii. Insurance cover only for the few who can afford it

Health insurance cover in the country is limited to various class of the citizen and only to certain sections of the country. The private insurance companies that exist have simply put it that they are here to do business and hence their strategy is to get the most from their investments. Hence, their offices and personnel are concentrated in the urban areas. To have a glimpse of the affordability issue take an example of AAR. It is one of the major stakeholders of private insurance business in this region. It has been charging its 'bronze' cover clients Kshs 15,100 [US $ 191], its 'silver' clients Kshs 18,350 [US $ 232] and its 'gold' clients Kshs 27, 200 [US $ 344] annually. These rates are far beyond the reach of majority of ordinary Kenyans.

iv Insurance cover and the vulnerable groups

There was a period in the 1990's when it was a policy of many insurance companies to demand that high health risk persons would not get cover from them even when they could afford it. This is still the case as far as Kenya is concerned, particularly in private insurance business. The argument advanced is that in insurance business, insurance cover is for the unpredictable circumstances and not for obvious eventualities. The cluster of HIV/AIDS patients consequently are *discriminated* against as a result since their health status and eventuality in life is clear. Definitely, social insurance schemes administered by the government such as National Hospital Insurance Fund [NHIF] should not even dream *discriminating* against such patients as the government is obligated to ensure that every one has the right to "social security including social insurance"[60]

The government has the delicate task of ensuring that the players in the insurance sector do not deny accessibility of vulnerable groups i.e. the terminally ill, HIV/AIDS patients, etc, to health insurance services if at all they can afford it. The government must "create conditions"[61], even if it is revisiting its schedule of specific commitments under GATS, (see conclusion section 4.2) that will guarantee the right to health facilities, goods and services [including health insurance], to **all**.

Actually, the WTO Secretariat acknowledges the dangers that may be inherent in liberalisation of healthcare services and insurance service in particular. In one of its notes[62] it says that "private health insurers competing for members may engage in some form of 'cream skimming' leaving the basic public system, often funded through the general budget, with low-income and high risk members. New private clinics may well be able to attract qualified staff from public hospitals without, however, offering the same range of services to the same population groups".

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[57] Information on statistics obtained from National Hospital Insurance Fund documents.

[58] Kenya's National Development Plan 2002-2008 Chapter **5**.2.11

[59] The National Health Sector Strategic Plan: 1999-2004 Chapter 4.20

[60] See Article 9 of CESCR.

[61] The Steps to be taken by the States [Kenya included] include " the creation of conditions which would assure to all medical service and medical attention in the event of sickness" See Article 12.2 (d) of CESCR

[62] 'Health and Social Services-Background Note by the Secretariat', Council for Trade in Services, WTO [S/C/W50]- 18/09/98. See also the recent joint WTO-WHO report: " WTO Agreements and Public Health" August 2002.

b. Financial services

Banks, which are under the category of financial services, in Kenya have in one way or another exacerbated the problem of healthcare access further in an opaque way than ever realized[63]. After the financial sector was liberalised and the government de-linked itself in direct control of *interest rates*, access to finances became difficult and prohibitive to the utmost. Even when access was available, *interest rates* were very high hence prohibitive even to local entrepreneurs who wished to invest in establishing healthcare facilities i.e. hospital, nursing homes, clinics etc. Those who would ventures in taking loans from such banks[64] transferred the cost incurred in establishing such facilities to the consumers of health care services. This arrangement compounds further the accessibility of health care services to the already-burdened consumers.

1.5 Commitments Kenya may make in the current negotiations

Kenya is poised to commit itself to further liberalisation in the wide spectrum of service sectors. This has to be done in line with the in-built agenda[65] within the WTO agreements, in this case GATS. The process of liberalisation is based on a member first seeking markets in another WTO Member country through the ***request*** approach[66]. This *request* phase has already started and some countries have already given their "initial requests"[67]. Kenya will be looking forward to market access in U.S.A. and U.K. in the nursing services for example. [See appendix 1]. It is possible, or is likely that, during the market access negotiations in the coming years, Kenya will be requested to do what it expects other countries to do for it. That is, it must be prepared to receive the request to open up its very own service sectors that it request others to open.

Other service sectors that have been lined up for request for market access in WTO members states include, *Construction services*, *Engineering services*, *Legal service*, *Educational services* etc, amongst others

Companies that dominate in the local scene in the construction, engineering sectors, for instance, are foreign companies. Hence, they may desire market access to other WTO member states and Kenya thereby becomes the leaping ground to such markets. It is the view of the author that, whereas nearly all sectors of the economy are essentially interlinked, certain sectors may have a direct bearing, or impact, on the healthcare sector than others may have. For example, insurance services, banking services [see section 1.4b above] etc. may have more direct impact than engineering or construction service have. So, on average, the commitments that Kenya may make at WTO may not make significant difference, in as far as affecting the social and health aspects of the citizens are concerned.

There is a strong push by creditor nations and funding institutions such as I.M.F. and World Bank that healthcare sector be liberalized further in order to cut down government expenditure. Seemingly, there is a consensus that since the portion of health care budget has had more funds going to recurrent expenditure, the trend is not sustainable in the long run. This problem was to be solved by systematically shifting the burden of healthcare to the citizens[68], and by encouraging investors in establishing commercial presence locally.

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[63] This is another angle of the GATS liberalisation in financial services leading to great difficulty of the locals who would wish to establish healthcare services commercial presence in their own territory virtually impossible. The author feels that this dimension of research can be undertaken separately and hence it appears here only as a mention.

[64] The banks here include leading multinationals such as Standard Bank, Barclays, Citi-Bank, etc, which in the period from mid nineties were charging averagely more that 27% interests rate on their consumers who took loans from them.

[65] For instance see GATS article xix

[66] See paragraph 15 of Doha Ministerial Declaration WTO Document WT/MIN (01)/DEC/1

[67] Ibid.

Interpretation of "initial requests for specific commitments by 30 June 2002" has rather been a puzzling affair. Many say that 30th June 2002 was the beginning of requests by members. Others say the phrase "by 30 June 2002" connotes a deadline of some sort.

[68] Introduction of User fees in public hospitals and clinics from the nineties was intended to serve that purpose. Actually, it was introduced by the government in December 1989 as a way of cost sharing.

1.6 Managing liberalisation

Whereas Kenya's commitment under GATS is not as wide as previously thought, nevertheless its coverage of the services sectors left to market forces is wide enough. The effort even to widen the scope of services particularly in the health care provision is increasingly imminent particularly now that it is public that Kenya is looking for market access in the developed and developing countries in the areas of healthcare services as can be seen in appendix I.

Whereas the government's drive to create a conducive environment to foreign investors in various sectors is understandable, nevertheless the need for *thorough assessment* in the specific service sectors is necessary now before any further commitment in the multilateral level is done. Take for example the conditions attached in Kenya's Schedule of commitment, that on the life insurance part. The condition that 1/3 owner ship of investment by the locals is not enough to guarantee health insurance cover for those who need it most. To ensure that Kenyan gains substantially from its commitment it can, through rescheduling its national treatment, and "in regard to private health insurance, require all private insurance plans - foreign and domestically-owned – to offer a basic package of benefits, prohibit "dumping" of high-cost patients onto the public system, and prohibit the exclusion of people with pre-existing conditions and diseases"[69]. This may in turn guarantee health insurance cover to the terminally ill, and the vulnerable groups in the rural areas. So far there is no mechanism to ensure that coverage of such services extend to these groups. Managing liberalisation that way may bring benefit to all. By the time of writing this research, there is a proposal by the government to introduce a law that will ban HIV testing by medical insurance companies and employers. This is contained in the draft *HIV/AIDS prevention and control bill, 2002*[70]. This bill or measure by the government came because of rampant discrimination that we have mentioned above on certain kind of people.

[69] See paragraph 233 of "WTO AGREEMENTS AND PUBLIC HEALTH" a joint study of WHO and the WTO secretariat.

[70] Section 13 says in part, "no person shall compel another to undergo an HIV test as a precondition to, or, for the continued enjoyment of employment or the provision of health care, insurance cover or any other service."

CHAPTER TWO
HEALTH POLICY IN KENYA

2.0 Health policy and law

Kenya has numerous laws[71] and regulations relating to the entire health sector in the country. Whereas health policies change due to the prevailing economic, social and political environment, the laws are more or else the same come year in year out. Amendments are made here and there to accommodate the changing policy framework environment when necessary. Some laws are more pronounced in linkage to the management of health in Kenya than others, i.e. Laws of Kenya, **The Public Health Act**, **Chapter 242**. This law establishes the Central Board of Health, which has a vital role of advising the Minister of Health upon all matters affecting the public health[72].

As have been mentioned elsewhere in this research work, the late 1980's and early 1990's were difficult economic times for Kenya. During this period, the government was not in the good books of the global financial institutions such as I.M.F./World Bank. Hence, government expenditure in the health sector had to be reduced gradually as the years unfolded. Funds were to be allocated to other sectors that the financial institutions recommended. The government policy on health had therefore to change to accommodate the new global order brought about by the SAP's. In **1994** the government through the Ministry of Health came up with a policy paper entitled "**The Kenya's health Policy Framework.**" The policy document clearly highlighted the new direction of the way things were to take in the years to come. That is a systematic de-linking of the government from active role in provision of health service to Kenyans. This is well captured by the words of the then Minister of Health, Honourable Joshua Angatia in his foreword to the document. He said,

> " the role of the central Ministry of Health will be transformed from that of a provider of services to that of policy maker and regulator of service provision."[73]

Various government documents have voiced the same line of thinking; the overt desire to de-link government from the mainstream activity of providing services. De-linking is not bad per se but should be done only when such kind of a move does not interfere negatively with the lives of the citizens. The private sector participation is more of a priority as of now. They are seen as helping alleviate the problem of unemployment and bridging the technological gap that currently exists between our country and others in the developed world, which they can easily import from their partners in the developed countries. Therefore, the government has committed itself in creating an enabling environment for these investors in all the sectors of the economy.

This not withstanding the government has, as it's overall goal until the year **2010,** one health policy, and that is **"to promote and improve the health status of all Kenyans through the deliberate restructuring of the health sector to make all health services more effective, accessible and affordable"[74].** This, in substance, is in line with article 12.1 of CESCR that obligates the States to take "steps"[75] that will lead towards full realisation of "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".

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[71] The Various Laws that relate to Health of Kenyans directly or otherwise include Cap. 242 Public Health Act, Cap. 244 Pharmacy and Poisons Act, Cap 248 Mental Health Act, Cap 253 Medical Practitioners and Dentists Act, Cap. 255 National Hospital Insurance Act, Cap. 254 Food, Drugs and Chemical Substances Act, Cap 246 Malaria Prevention Act, Cap. 243 Radiation Protection Act, Cap 245 Dangerous Drugs Act, Cap 257 Nurses Act, Cap 260 Clinical Officers (Training, Registration and Licensing) Act.

[72] Laws of Kenya, The Public Health Act, Cap.242 section 3(1) and section 8

[73] Government of Kenya, Ministry of Health, KENYA'S HEALTH POLICY FRAMEWORK –November 1994

[74] Ibid, part 2

[75] CESCR article 12.2

2.1 Concept of a healthy nation

The government accepts that the goal for its policy is to achieve in practical terms the definition of health as elaborated by **W.H.O.**, that is, "Health is state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." It has put upon its shoulders the role to "promote and provide quality, curative, preventive, and rehabilitative health care services to all Kenyans"[76].

2.2 Health for all, programme and plan.

The plans and programme to achieve health for all and which "will ultimately increase the longevity and quality of life of Kenyans"[77] is contained in the national health sector strategic plan1999-2004 as mentioned earlier. Whereas the plan is good, it does not address adequately ways in which access and affordability of health care will be effectively supplemented by "commercial presence" of foreign healthcare providers. A simple check of foreign healthcare providers' and even local private practitioners' daily charges in the hospital can give the picture of why affordability is still an issue (see table 3c). Ministry of health seemingly will be the **regulator** for a long time to come yet it has the role of promoting and **providing** health care to Kenyans, this obviously brings conflict of interests, which may not augur well with foreign health providers who may wish to establish commercial presence here.

2.3 Health care financing in Kenya

The main financier for health service in Kenya is the government itself. The private sector, the non-governmental organisation and other civil society groups supplement this role too, though not in the same measure as the government. "The government provides approximately **43%** of the funding and the remaining costs being shared among religious organisations, other NGO's and private providers"[78]. Much of these funds go in paying salaries to medical staff and meet other recurrent expenditure.

The government in **1989** introduced **cost sharing** in health care services in government hospitals and health care centres. The government stated then that: "the objective of user-fees is to increase the government's financial capacity to provide good quality healthcare in the face of the increased cost of the health care"[79]. A patient was henceforth expected to pay for the previously free service. "Out patient user charges were subsequently suspended in September 1990 owing to declining utilization of health services. The cost sharing system was, however resumed in 1991"[80] presumably due to external pressure.

2.4 Structure of our health care system

The health care system in Kenya is structured in a pyramid like pattern as shown below in **figure 2.0**, and "as one moves upwards, the level of sophistication and complexity in diagnostic and therapeutic care increases"[81]. In the structural framework that is exemplified by the figure below, contributions are made to fill every stratum by the private health service providers and voluntary agencies- these include religious organisations, industrial health units, private health institutions, individuals, and NGO's not to mention the Central government through the ministry of health and the local authority especially the municipalities. Many linkages with the private sector and nongovernmental organisations come in handy to help the government health care system. They must all get the licence to operate from the government. From this point onwards whether they offer quality service or not, whether they deny access of healthcare by prohibitive cost of service to the poor, the government does little to interfere. For example in Nairobi, while having the main national referral hospital [**Kenyatta National Hospital**], there are other private hospital such as

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[76] See Chapter 2 of "Republic of Kenya, Ministry of Health- The National Health Sector Strategic Plan: 1999-2004" document.
[77] Ibid.
[78] National Development Plan 1997-2001-Section 6.8.7
[79] Development Plan 1994-1996 -Section 11-36
[80] See section 6.54 of Kenya's National Poverty Eradication Plan 1999-2015
[81] Kenya at the crossroads, scenarios for our future, Institute of Economic Affairs, 2001 Chapter 6

Nairobi hospital, Aga Khan and **Mater Meriscordiae** hospital which are regarded highly as referral hospital too and frequented by the well to do citizens.

Figure 2.0

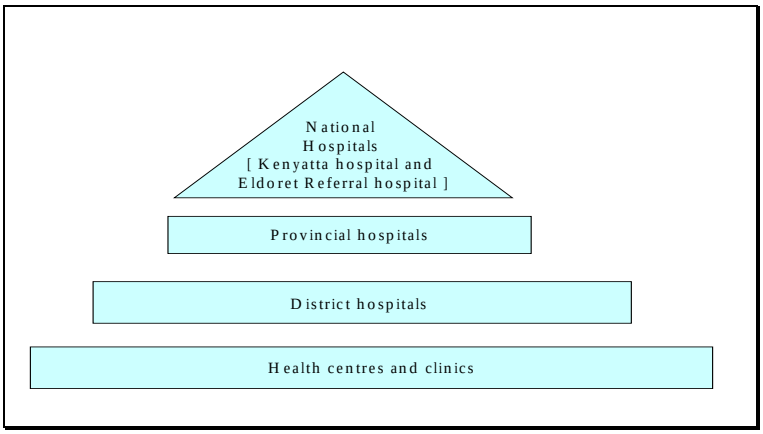

Figure showing the structure of health system in Kenya

2.5 health care access to all

In spite of all this proper rationalized structure of healthcare system in the country, healthcare is not ***accessible*** neither ***affordable*** to all. The government admits that this "unfavourable distribution of health services continues to widen with observed disparities in access and affordability across the country"[82]. The government's acknowledgement of these "observed disparities in access and affordability" of healthcare services means the guarantee that all Kenyans enjoyment of the "right to the highest attainable standard of health" is still dream. Even with the declared position that the government role will be to "create an enabling environment for private sector"[83] in healthcare service provision, it is puzzling why health for all is not accessible and affordable yet[84]. Healthcare provision business is very lucrative in Kenya, at the moment, for the private sector players. As can be deduced from table 3c they charge exorbitant charges to patients who visit them compared to other government health facilities or mission hospitals. Yet, they never experience the need to bring down the charges, as all seems to be going well with them. However, it is increasingly clear that this fact does not translate itself in Kenyans enjoying the *assumed* benefits associated with foreign "commercial presence" of the healthcare traders.

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[82] Kenya's "National Development Plan 2002-2008" section 5.2.3

[83] Chapter 2.6.5 of The National Health Sector Strategic Plan: 1999-2004

[84] Some claim that the reason why this is the case is simply because of wrong macro and micro economic policies employed by the government that has resulted into widespread poverty among Kenyans. Others have tried to establish links with wrong or rather inappropriate advice given to Kenya government by I.M.F./World Bank in the eighties and nineties. The later line of comment emanates from the Economic Structural Adjustment Programmes prescribed by the Bretton Woods institutions then, which resultantly saw an increase in the level of poverty.

CHAPTER THREE
IMPLICATIONS OF MODE THREE IN KENYA

3.0 Mode three

"'Mode 3' process involves mode of supply of service through the *commercial presence*[85] of the foreign supplier in the territory of another WTO member."[86] A good example is when a British health service provider establishes a subsidiary in Kenya to offer health services here, or a health insurance firm from say, U.S.A., establishing a branch in Kenya for the purpose of offering a health insurance services.

3.1 Beneficiaries of mode three

It has been argued in many forums locally that, whereas commitment to mode three in any service sector may in the long run attract foreign direct investment [FDI] in terms of commercial presence, the main beneficiaries nevertheless are the multinational companies. Even globally, it has been recognised that this is the true state of affairs. In Africa mainly, the beneficiaries of FDI [87] are the multinational companies after all. Because of rules within the GATS system[88] that allows the service providers operating within the limits of the "specific commitments" under a country's schedule to repatriate their profits back to their home country, it becomes difficult to really contain such capital to serve the "economic development" purposes in the country's agenda. Even when it has been allowed to "adopt… restrictions… on payments or transfers for transactions related to such commitments"[89] the process is cumbersome, time consuming and prohibitive to say the least to such developing countries like Kenya.

The facts above must be borne in mind before a country rushes to lure foreign investors to establish commercial presence in any service industry more so in the ***health*** sector.

3.2 Possible impacts from a mode three aspect

Table 3a

Possible impacts of implementing mode three in Kenya in the Health sector			
Supporting articles in the WTO agreements, other international agreements and national laws/policies, if any.		A	B
		Benefits/Losses to the Service Provider and his home country	Benefits/Losses to the Host Country
1.	**Article xi and xii of GATS**	The Service Provider can repatriate all his profit to	a. Host country can experience balance of

85 "Commercial presence" means any type of business or professional establishment within the territory of a member for the purpose of supplying a service. See GATS article xxviii. d

868686 WTO Secretariat. Trade in Services Division October 1999

87 "Measured as a transfer of financial resources from rich to poor countries, the benefits of FDI have been wildly exaggerated. Simple accountancy helps explain why. Figures on FDI inflows are often assumed to represent a net transfer of resources, which they do not. Repatriated profits constitute a financial outflow which must be set against any inflow associated with FDI These are very large. For sub-Saharan Africa, profit repatriations represents three quarters of FDI In other words, for every **$ 4** that enter through FDI, **$ 3** leaves in the form of profit transfer, [World Bank]". Quoted from RIGGED RULES AND DOUBLE STANDARDS: trade, globalisation, and the fight against poverty. MAKE TRADE FAIR- Oxfam International, Chapter 7

88 See article xi.1 of GATS

89 GATS article xii.1

		his home country, except if the IMF and other WTO members agree that there are balance of payments problems	payment and other problems associated with capital flight
2.	**GATS Article iv. 1 a and Article iv.2.c**		b. Transfer of technology to the host country (benefit) or not receiving the latest technology (loss)
3.	**GATS Article article xvi**	Wider market access for the services of the Provider	c. Envisaged **cheaper** and **quality** services [probable]
4.		Investor may get good returns as a result of cheap labour force, little or no competition at all and other factors that may have attracted him to the host country	d. Capital flow [FDI] to the host country during the early periods of investment by the service provider
5.			e. FDI can help reduce the burden on government resources which then could be directed to improving the public sector[90]
6.		Service Provider home country citizens may have international experience once located in the host country	f. Possible employment creation
7.	**GATS article vi.4, article xvi**		f. The Host country looses, to some extent, the ability to regulate the specific service sector or sub-sector

Source: Consumer Information Network -2002

3.3 Mode four of service

As can be deduced from appendix 1, Kenya expects to derive so much through **mode four** aspect in many of the requests and probable commitments in future for obvious reasons. A huge segment of the population is unemployed. By requesting market access in other countries, this mode of trade will help towards solving the problem of rising unemployment amongst the *trained* labour force. This is service conducted through movement of "natural persons"[91] to another country to offer a specified service.

This might appear appealing but it too has some potential negative impact of leaving the country with a deficit of manpower in the committed service sector, now that there will be motivation for greener pastures abroad. This mode of service may lead to "the loss of health professionals to cater for foreign consumers…" and may "threatens to undermine still further national health systems"[92] in the overall aspect. Actually this a confirmed fact since the government documents say "the ratio of medical personnel to a **100,000** population decreased from **190.1** to **188.2** in

[90] See UN Document No. E/CN.4/Sub.2/2002/9, article 43 of the report of the High Commissioner.
[91] GATS article i.2d
[92] The wrong model: GATS, trade liberalisation and children's right to health. Chapter 5 section 6.

2001"[93]. The government alludes the problem to "partially be attributed to medical personnel leaving the country to seek better employment opportunities elsewhere"[94]. Current problem that exist in public health sector of "retention of medical personnel in the public health facilities"[95] will only exacerbate.

3.4 Actual situation: foreign presence in health in Kenya

a. Hospitals and health centres

Kenya is host to various foreign health service providers and other healthcare related services such as health insurance as can be seen in table 3b. Some institutions have had "commercial presence" here for too long and it is difficult to distinguish whether ownership is local or foreign. Others have been able to integrate themselves with local staff and environment that one would easily think that they are local [Gertrude and Nairobi hospital are a good example]. Since these private hospitals are investments by religious groups or individuals [Matermeriscordiae and Aga Khan Hospitals] and their families, it was difficult to get actual data on how they are run, and where the profits go to etc. It is good to mention here that many of the hospitals contacted felt that giving out certain information relevant to this research may be used against them in the wrong way, hence the reluctance to divulge vital information. Moreover, even those who gave various kind of information gave it on condition that they are not quoted for the sake of job security. For example, how will one treat a poor penniless patient who comes in a hospital that once operated from a humanitarian point of view but lately turned into a full-scale commercial hospital? Would such hospital turn away such patient? Will they treat such patient until he/she recovers? This kind of questions always met diversionary answers. Other hospitals would only give the front office type of information that would not have been relevant to this research.
This not withstanding it was obvious that if one was in business one was there to make profits hence the motivation not to offer free medical healthcare even to the absolute poor was evident in all the private hospitals foreign and local. The same applied to health insurance services.
Many of the hospitals studied [if not all] would not retain a person for long if they discovered he/she was having some problems in paying the hospital bill. If the hospital discovers that a patient does not have insurance cover and that initially the patient had paid some deposits in cash form and the payment thereafter proved to be not forthcoming the patient would

- receive **discharge letter** to vacate the hospital even in cases where it was evident that more specialised healthcare services ought to have been accorded the patient.
- be transferred to the nearest public hospital even when it was clear that he would have gotten better off health wise in the private hospital.
- be unduly detained and probably forced to work i.e. clean the floor, wash some garments, etc. until that time that some sympathetic Good Samaritan or friends and relatives find some cash to bail out the patient. When no one is forthcoming for the rescuer, the patient would finally be discharged but having suffered even more psychological trauma.

b. Insurance companies

Some major insurance companies that deal with health insurance amongst other forms can be seen in table 3b. As had been mentioned earlier on [section 1.4.a. on health insurance], many of the insurance companies have one-third paid up capitals by Kenyans. Quite a number of the foreign investors would not want to share benefits with Kenyans and the author is of the opinion that total ownership will be one of the "requests" that Kenya may receive from countries such as America and Britain etc. who have major interests in the insurance sector besides other modes of wider market access. The major foreign firms in this regard are shown in the table below.

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[93] Kenya' Economic Survey Chapter 3 section 3.30
[94] Ibid.
[95] Kenya's National Development Plan 2002-2008 Chapter 5, Section 5.2.3

Table 3b. Foreign healthcare service providers [and related services] in Kenya

Institutions		Ownership	Core functions (health and health-related services)	Main Location of Operation
Foreign Hospitals[not necessarily multinational]				
1.	**The Aga Khan**	Asian	Hospital services	[Nairobi, Mombasa, and Kisumu]
2.	**Nairobi Hospital**	British/Kenyan	Hospital services	Nairobi
3.	**Gertrude Children Hospital**	British /Kenyan	Hospital services for children	Nairobi
4.	**Islamic Republic of Iran Medical clinics**	Iran	Clinics [by the time of writing this report- very soon to offer *in-patient* services.]	Nairobi
5.	**M.P. Shah**	Asian/kenyan	Hospital/Clinics	Nairobi
6.	**Chinese clinics**	Chinese nationals	Acupuncture, Herbal, Gynaecological/ Paediatric/Obstetrical	Nairobi, Mombasa, Nakuru,
7.	**Amref**	N.G.O.	Medical/Ambulance	Nairobi
Health Management Organisation [HMO's]				
8.	**HealthFirst International**		Health insurance services	Nairobi
9.	**Strategis Health**	Subsidiary of Strategies Africa. Owned by Trans Zambezi Industries [Zimbabwe]	Health insurance services, ambulance services, etc	Nairobi
10.	**Medex [The biggest HMO in Africa]**	Owned by Hannover Re [American] &NetCare [S. African]	Health Insurance services	Located in More than 20 major towns in Kenya.
11.	**AAR**	British/ Kenyan	Health insurance services	Nairobi [and many towns of E.Africa]
Insurance companies [Multinationals]				
12.	**ALICO**	American	Life insurance [health insurance inclusive]	Nairobi Mombasa
13.	**Jubilee Insurance**	Asian [Aga Khan connection]	General, Life insurance health insurance inclusive]	Nairobi Mombasa
14.	**Madison Insurance**	American/Zambian	General, Life insurance health insurance inclusive	Nairobi
15.	**Apollo Insurance**	Asian Ownership	General, Life insurance health insurance inclusive	Nairobi, Nakuru, Mombasa
16.	**British American Insurance**	British/American	General, Life insurance health	Nairobi

			insurance inclusive	
17.	**UAP provincial insurance**	Kenya	General Life insurance health insurance inclusive	Nairobi

Source: Consumer Information Network- 2002

3.5 Assessment of the impact on the right to health and access to health services

Kenyan government is signatory to various international covenants that respect the dignity of human beings and the right to self-determination. It has frequently declared commitment to the respect for human rights. This has principally been so in its adherence to various treaties such as UN Declaration on human rights and is even party to the states that have ratified the international covenant on economic social and cultural rights [CESCR], which it acceded to on 1st, May 1972[96]. These human rights include "the right of everyone to the enjoyment of the highest attainable standard" of health.

To safeguard the right to health these treaties obligate the state to create an enabling environment to which citizens are enabled to enjoy their health. The state has consequently attempted to do so by building Hospitals, dispensaries and clinics are all over the country to achieve this objective. (See the pyramidal structure of the plan in figure 2.). This effort not withstanding, the goal is yet far from achieved since according to CESCR the state "must make available functioning public health, and health care facilities"[97]. This cannot be described as the true state of affairs in the country.

a. Right to health

When one analyses whether the presence of foreign investors in the healthcare services has helped or hindered the right to health amongst Kenyans, there are various factors that have to be looked into before one can reach any logical conclusion in that direction. These factors include

1. Ability of an individual to pay for the healthcare services offered.
2. Accessibility of such healthcare services. [Distance from the service centres is a contributing factor in accessibility.]
3. Quality & and quantity of healthcare services offered. Some smaller hospitals may have the best quality but may not accommodate every body who can afford because of size.
4. Intimidation of seeking healthcare services from expensive foreign hospitals because of real or imagined persecution for non-payment.

All this factors can hinder the realization to the right to healthcare.

b. Insurance cover

Insurance cover, particularly on health, has increased as a result of foreign investment in the same area. This nevertheless does not mean that access to health care services has been more enhanced by this increase. Factors that have emerged as a result of this increase can be analysed as consisting of the following.

1. The people who are covered by this insurance companies were previously able to pay directly to hospitals for the same service. It is therefore just a means of convenience and a "feel" of enhanced status of life on the part of the clients when they subscribe.
2. Many of the uncovered are poor and see insurance cover as a luxury they cannot afford. It is expensive to the large population particularly in the rural areas.
3. Main insurance companies have enjoyed good relation with HMO's. The later act like intermediaries and ensures that insurance companies do not loose money through cheats who claim for refunds in collusion with healthcare providers. *The first HMO was established in Kenya in the 1980's and the number has risen since then. This was as a*

[96] Office of the United Nations High Commissioner for Human Rights. Status of Ratifications of the Principal International Human Rights Treaties as of 8th February 2002.

[97] See the United Nations Document E/CN.4/Sub.2/2002/9. Article 29a. ECONOMIC, SOCIAL AND CULTURAL RIGHTS. Liberalisation of Trade in Services and Human Rights. Report of the High Commissioner. Executive summary.

result of misuse of the insurance facility offered by the companies. "Most insurance companies writing health insurance started incurring losses through fraudulent claims made by their medical policyholders"[98]. Since this is still possible many insurance see the HMO as blessing since they are relived of the task of dealing directly with the client.

4. HMO's are thriving because they have no **regulator** to govern their activities, neither do they have a code of conduct to ensure ethical standards are upheld. They are potential danger to the health of Kenyans in that they can collude with medical practitioners to discharge you from their selected hospitals if you are depleting resources from those hospitals by taking long to get well [this has reportedly been the case in some instances]. The administrators of HMO's can advise the hospital or the medical personnel to discharge even when you are not yet well due to the increasing cost of keeping you in the hospital.
5. Some HMO's have 'seemingly' been funded by multinational insurance companies or other interested parties. In particular are those that appear or are known to have began locally, their upward success stories within a poor economic environment begs many questions. The assets and financial muscle at their disposal within a very short period of their existence, lends to the thinking amongst many that they may be acting on behalf of, or in collaboration with, other multinationals, possibly insurance companies. The relationship with insurance companies is suspect.
6. HMO's will unashamedly demand to know your HIV/AIDS Status so as to take decision on whether to insure you or not, yet foreign insurance companies will not do so to avoid controversy. Hence, the good bond between the two as result of the complimenting roles each play.

Table 3c Major hospitals in Kenya

	HOSPITAL	***DAILY CHARGE in Kenya shillings***	***LOCATION***
1.	KENYATTA NATIONAL HOSPITAL [AMENITY WING] [Kenyan Ownership]	1950	NAIROBI
2.	H.H. AGA KHAN [Foreign ownership]	3550	NAIROBI
3.	NAIROBI HOSPITAL[foreign ownership]	3400	NAIROBI
4.	MATER MISERICORDIAE HOSPITAL [Owned by Catholic Church] Purely run on a commercial basis.	2950	NAIROBI
5.	GERTRUDE GARDENS CHILDRENS HOSPITAL [foreign ownership]	4500	NAIROBI
6.	KENYATTA NATIONAL HOSPITAL [GENERAL WARD][Kenyan owned]	300	
7.	S.S. LEAGUE M.P. SHAH HOSPITAL	3000	NAIROBI
8.	P.C.E.A. KIKUYU MISSION HOSPITAL [Kenyan Owned]	400	
9.	MAGADI SODA COMPANY HOSPITAL [British/Kenya]	2000	RIFT VALLEY PROVINCE
1(	GENERAL HOSPITAL MOMBASA [Kenyan Owned]	100	COAST PROVINCE
1:	DIANI BEACH HOSPITAL	1600	COAST PROVINCE

SOURCE: Consumer Information Network 2002
Approximately: Kshs 78.00= US $ 1[2002]

[98] Statement made by Sammy Makove, the Commissioner of Insurance in Kenya during an Expert Meeting organised by C.I.N. on 19th July 2002 at Silver Springs Hotel.

3.6 Hasty liberalisation of health sector.

With the current high poverty levels in the country and the poor shape of the economy, it is reasonable to say with a measure of confidence it is not yet time for the government, through the ministry of health, to offload the task of providing health care services to Kenyan citizens. The poor citizens have little or no capacity at all to meet the full cost of health care services without heavy subsidy from the government.
Some of the problems encountered in this respect of liberalisation include the following.

- Many people don't have insurance cover. Any accidental health problem that necessitates a person to seek hospitalisation will be virtually impossible (many of the hospitals' charge is more than 300 Kenya shillings a day) bearing in mind that majority of Kenyans live below the poverty line level, that is, they earn below one dollar a day (less than 78.00 Kenya shillings). See table 3c
- Many of the hospitals, particularly foreign owned, are located in the urban areas where we only have approximately 25 % of the population.
- The temptation even to go commercial has prompted the government to have two services within the national hospital (Kenyatta National Hospital) with one serving as a private wing and the other serving in a subsidized manner. The problem with this is that the best care is with the private wing as opposed to the general wards where it is so congested with patients that they even share hospital beds. Drugs and other facilities are always available in the private wing whereas this is not the case with the general wards.
- The best medical personnel, nurses, dentists, etc move from the public sector to the private health care service establishments[99, 100, 101]. This leaves the public health care sector with less experienced and, in some instances here and there, with no medical personnel at all.
- The frenzy to liberalise the health care sector in Kenya, came to the fore after introducing the **user fees** in public healthcare services in the 80' and 90'. In the background of an ailing economy, health care centres in the urban and rural areas looked like ghost houses since many patients opted either to stay with their conditions or sought medical treatment in the traditional herbal way rather than pay hefty medical bills beyond their means. These options made the poor more vulnerable to much danger health wise.

The above information clearly illustrates the predicament Kenya is in when it comes to healthcare service liberalisation. It is evidently not yet time to commit the health service sector in a multilateral set-up of trade. Folks here are too poor to actually adjust and benefit from a multilateral trade set-up of trade in this service. For the government to ensure that "payment for health care services, as well as services related to the underlying determinants of health is based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all"[102], and having taken into account the prevailing economic environment, it must not commit such services under GATS. If it does, the goal of attaining "the highest attainable standard of health" will be simply be out of reach.

3.7 Assessment of the impact on society as a whole

Some of the complaints [or real or perceived **problems**] that one comes across immediately in the Kenyan scenario in health care services include the following, *inter alia*;

Health care services

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[99] The Kenya's National Development Plan 1997-2001, section 6.8.10 talks of "many experienced staff leaving the public service for the private sector".
[100] See also Kenya's health policy framework November 1994 section 8.
[101] See Section 3.30 of Kenya's Economic survey 2002 for further information on the same.
[102] United Nations Document, E/C.12/2000/4, CESCR. General comment 14. 4th July 2000

- It is expensive for me to take my self and household members to the hospital when the need arises.
- The daily charge of some hospitals are extremely expensive hence only meant to cater for the rich. *See table 3c*
- Drugs are very expensive at the pharmacies [bearing in mind that more than **56%** of Kenyans live below the poverty line]. *One major practise employed by public and private (including foreign) hospitals, is to divide the type of service they offer in various format. There is consultation, diagnosis, treatment, hospital services (this include bed, breakfast, meals, etc) and pharmacy. All this components of service delivery, the patient is supposed to pay a fee. You may receive the best consultancy and diagnosis in the foreign hospitals, but you may be unable to pay for the drugs making the whole process futile.*
- Private hospitals demand money first (unwritten policy) before delivering the service, even when the patient is suffering much. *It is appropriate to mention here that the hospitals encourage this practise are all hospitals listed in table 3c. and many more not mentioned in that list. Many styles of delay tactics may be employed to verify whether the patient and those who brought the him/her to the mentioned hospitals may give up and seek alternative treatment elsewhere, i.e. public hospitals. If the worse goes to worst, the hospital may offer some form of belatedly first aid so that the patient does not die in their premises.*
- Even when admitted to the nearest hospital [more so private hospital, the patient is nagged by hospital staff to show evidence of his/her ability to pay for the services. If the response is negative then he/she is discharged when the treatment is not complete. *See section* 3.4 a
- Private hospitals have no wards dedicated to poor and helpless patient.
- Accident victims find admission to the nearest hospital virtually impossible, whether private or public, if they prove unable to pay.
- The health/medical practitioners prescribed for me the wrong medicine.
- The quality of service in both public and private hospitals and health centres is poor.
- It is wrong and inhuman to chain prisoners who fall sick to their hospital beds while undergoing treatment. *See section 3.4a*
- Medical practitioners should not engage themselves in business like activities in the health sectors since they may be compromised if their poor patients are taking too much of their time and space in their respective business premises.
- The working relationship between health insurance companies and hospitals or health clinics sends very wrong messages to those who are insured. *The insurance companies keep close scrutiny of their clients account and when it "befriends"[103] the hospitals he frequents most, then the scenario gets scary to most of the insured*.
- Public medical practitioners should not engage themselves in profit making endeavours in own private clinics and public service at the same time. They may dedicate more time and resources to the former than the latter.

Health insurance services

- Health insurance companies are not interested with the poor.
- Health insurance cover is only for the rich
- Reimbursement of claims is cumbersome and unduly takes long.
- Close cooperation or association with the hospitals or health clinics where one is admitted is worrisome.

As one can quickly conclude from the foregoing, this is a desperate cry from the masses of the Kenyan populace. Though the above chronology of outcry from the public is far from exhaustive, it nevertheless gives a glimpse of where we are in terms of attaining the highest standard of health care system. Something, somewhere, need to be put right for the right to health to be fully realized by all and for all. Whereas jobs have been created by "commercial presence" of foreign

[103] This kind of friendship exists in Kenya, for example, the British American insurance Company may have a joint activity with Nairobi hospital or Gertrude's hospital.

health care providers, it is obvious that they have neither helped in solving many of our problems in the health sector. For example, they are the most expensive (see table 3c) than all the other local hospital and healthcare service providers. The commercial presence of these providers has encouraged the mass exodus of medical practitioners from public healthcare institutions to private providers. This has resulted in shortages of medical personnel in many of the public health centres yet they are the most frequented by the poor strata of the population of sick Kenyans. Should we encourage commercial presence of healthcare service providers in the country, and if so, should it be done in a multilateral setting of WTO? This and many other similar questions demand careful and serious thought from the government officials.

CHAPTER FOUR

CONCLUSION AND RECOMMENDATIONS

Governments of the world, through the help of WTO and other global institutions, are systematically handing over their role as providers of basic services such as providing water services, electricity, health services, etc to private hands. The handing over process to private merchants, local and foreign, is well facilitated, through design or otherwise, by the GATS agreement that more or less guarantees the investors' interests are uppermost compared to, say, human rights of citizens. This is understandably so, we have been told, because the trade organisation is not a human rights organisation. We have been sweet talked to believe that ultimately all shall be well, and that the market forces of supply and demand brings out the best to every country that opens up its market to investors.

On the other hand, and indeed in sharp contrast, we are seeing increasing discontent brewing amongst the citizens of the world, as was evidently exhibited by demonstrations in places like Seattle, U.S.A. during the 3rd WTO Ministerial Conference and Genoa, Italy just recently, against unchecked globalisation.

Many feel that basic human needs such as water, energy, healthcare, etc. are not items to be brought under a multilateral set up of trade. These are basic human needs, and therefore need to be left to governments (particularly those from developing countries) and their citizens to decide on what they want to do with these services. It is a strange idea, indeed convoluted one, to have governments totally abdicate their role of *controlling*, *regulating* and when necessary *providing*[104], for instance, health care services. It would not be prudent to hand over these noble roles to merchants who are in the business to make profits. One has to understand the mindset of the investor; he has the primary interest of making profits and not just to *provide* healthcare needs of the poor rural folks out there on a humanitarian ground. Further to this, what would be the scenario if the **entire** health sector of a country is in the hands of rich service providers from the territory of a perceived enemy and a war breaks out between the two nations? There are many good reasons as to why many nations of the world have for a long time firmly guarded against the liberalisation of these sectors. These reasons are still legitimate.

For instance, trading in education, water or *healthcare* services in California in the U.S.A. may enhance quality of service and promote creativity and consumer choice in that specific sector as the service providers compete for clients in the lucrative market. Without any strong government control or interference, the well being of Californians will be enhanced overall to say the least. But this might be detrimental to, say, Kenyans who are poor[105] and even opening the market for the same kind of investors from California, though they may come with the state of the art technology, may be dismayed because the market is not conducive for them, to make desirable profits. With this in mind, it will be wrong to *push* such a poor nation to open its service sectors to the market forces of demand and supply, *laeissez faire* style, when its government's prime agenda is to cater for the marginalized segments of the population. Yet, private commercial service providers cannot do this kind of service, whether local or foreign. This is what this paper has tried to espouse all along.

4.0 Dangers inherent in health care liberalisation

Problems will always abound when decisions are hastily arrived at without proper and adequate stock taking and wide consultation amongst stakeholders. Some of the major problems that Kenya shares with other developing countries, particularly from Africa, include the following.

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[104] It is important to note here that Kenya government provides health care services, though admittedly poor. As can be seen in table 3c the government owned Hospitals are the cheapest hence affordable and accessible to many as compared to private sector.

[105] Current level of poverty in the country is 56% of the population. See National Development Plan 2002-2008, section 2.0

1. **Brain–drain**: in Kenya we need not belabour this point, since its public knowledge that many health professionals think that this is not the right place for them to work and get the desired returns that they seek. Private foreign hospitals have neither helped solve the problem as earlier envisaged, though they remunerate their staff slightly better than public health institutions. *Many are accused of not remunerating local staff on equal terms with foreign staff, yet working in the same environment and having equivalent qualifications*. Consequently, our health professionals have gone to other countries to look for better job prospects, like the 300-plus Kenyan health professionals in Botswana currently. There is a definite need to look into the welfare of the medical professionals and remunerate them appropriately. This will retain them here to offer the needed service to the community. Others argue that it is more appropriate to have "brain drain than brain in the drain", but it is clear that if such mass exodus of the best brains in the society seek plum jobs abroad, ultimately, the nation itself may go "in the drain".

2. Despite of the difficulty to finance healthcare and the general poor economic performance in Kenya in recent times, quite a sizeable number of patients could afford to leave the country for treatment in foreign countries. Even though this has been done through private means or through public fundraising, it is believed to have caused great **outflow of financial resources.**

3. **A two-tiered system** with higher quality being accorded to foreign patients -alongside rich domestic patients- is one distinct offspring of inappropriate liberalisation in healthcare. Even with scarce statistics available, it is not far from the truth to state the fact that the "commercial presence" of foreign health providers in Kenya attracts substantial number of patients from the region especially from countries that are not politically stable hence, pushing poor Kenyans who can not afford to pay for these services to the periphery.
   When the business is good and foreigners jam specific hospitals, then the local patients get a raw deal. Incidents abound where patients have been transferred to public hospitals before completing treatment where ability to settle bills is in doubt. The fate of such poor patients is sealed when wealthier patients probably from warring neighbouring countries are ready to occupy such hospital beds instead. It is prudent from a business point of view for the hospitals to allocate space to those who are able to pay no matter their nationality.

4. The likely hood of **importing highly infectious diseases** like the *Ebola fever*, etc, is heightened. A good example is what happened sometimes back in Kenya in the year 2000 in Nyeri District in Central Kenya. One scary *Ebola-like fever* case was reported in the press, yet it is suspected the origin of such fever was from the central Africa region. This is indicative incidence that careless liberalisation trade in healthcare services can bring about an escalation of and spread wide of strange diseases that can prove to be catastrophic to human beings.

The problems elaborated above may be compounded when healthcare sector is brought under multilateral trade setting. If governments were to address these issues, by taking certain trade "measures", they would be deemed to "constitute unnecessary barriers to trade in services"[106] in that sector if they affect[107] the service.

4.1 GATS in conflict with human rights

Though it might be a complex affair to pinpoint the specific verses in GATS text that are in conflict with economic, social and cultural human rights, it is appropriate to highlight some parts of this text that may lead to, or encourage contravention of human rights.

[106] GATS article VI. 4

[107] GATS scope 'applies to measures by members affecting trade in services', see article I. 1 of GATS

Slight mistakes that a country like Kenya makes while scheduling its *specific commitments* to liberalise services can be very costly if they affect the enjoyment of human rights or when the citizens demand that they be rectified. **Article XXI** of GATS is punitive to say the least. Once a country has committed a specific service in its schedule, it is designed to stay that way permanently. Measures to amend any kind of past mistakes through compensation to the affected parties "shall be made on a most favoured nation basis"[108], meaning, compensate one compensate all. The very thought to "modify or withdraw" a commitment is strangled in its nascent form through such GATS clauses. The latter also stipulate that the process to make modifications can only start three years after the commitment entered into force. Low-income countries like Kenya cannot dare take measures to amend commitments, even when the populace demands so or need it to have their economic, social and cultural human rights be respected.

A government service, as mentioned in this study, that is supplied "on a commercial basis", or "in competition with one or more service suppliers" as mentioned in GATS **article I.3c,** is bound to interfere with the full realization of human rights. The argument is as follows. When the government endeavours to create "conditions which would assure to all medical services and medical attention in the event of sickness"[109], such as directly providing healthcare service for a small fee[110], or establishing a health insurance scheme that is affordable to all, the act may be interpreted to mean that the government is competing with other health care providers or insurance companies. This is brings the government services under the general provisions of the agreement according to **article I.3c** of GATS

4.2 Conclusions and Recommendations

The very notion that healthcare services be traded, and therefore be under the general dictates of the principles of economics goes against the cultural beliefs[111] and traditions of the citizens of this country. A sick person[112] in the society needs help and should not be seen *merely* as another statistics to warrant investment in healthcare services, and for that matter liberalisation of the sector.

Actually to many, this is building a critical mass of cultural shock that needs careful massaging as we increasingly see mistreatment or outright rejection of the less fortunate members of the society being denied a basic human right, ***the right to health***, on the simple premise that they can not afford it. (See section 3.7). Ability to pay for healthcare services should not be the criteria for accessing the same.

The architects of GATS made very grave assumptions[113], though this may not appear anywhere in the agreement, that governments progressively disengage themselves from providing, governing or interfering[114] in service provision even of basic needs search as water, ***health***, education, etc. every country that has committed such service in its schedule of commitment.

While having a good healthcare policy and plan for its citizens it is evident that Kenya like many other countries in the region have the problem of effectively ensuring that every person enjoys

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[108] GATS article XXI. 2.b

[109] Article 12.2 (d) of ICESCR

[110] This can be done through "a commercial basis" but affordable to the public by subsidization by the government.

[111] It should be borne in mind that many nations in the African continent got their independence as recent as in the 1960's (Kenya included). Traditions across the continent before then, were such that traditional healers, or medicine men, would usually be seen as divine beings who "helped" as opposed to trading in their gifts or art of healing. A sick man would not have been turned down or dismissed from the benefit of such persons' skills simply because of lack of money.

[112] It is estimated that more than 700 Kenyans die daily because of HIV/AIDS related diseases.

[113] By providing in the List of services or sub sector in services, an item sector like Healthcare services, is in itself indicative that in their minds basic human needs like water were to be opened up for multilateral trading system.

[114] The ability of the government to interfere with a liberalised services sector is greatly curtailed by such provisions as found in GATS article VI. 4.

"the right to the highest attainable standard of health". The "observed disparities on access and affordability" of healthcare provision mentioned earlier on (see section 2.5) can only be effectively addressed if Kenya, upon committing itself in healthcare service liberalisation ensures that in its GATS Schedule of commitments it puts up conditions or measures that will obligate investors to direct some of their resources to less marginalized communities. [As mentioned in section 1.6.]
As trade liberalisation expands in its scope, it becomes important to consider some of the following points before committing the healthcare service sector to a bilateral, plurilateral, or multilateral setting.

(a) Establishment of regulatory body

It is important to put things in their right order and to introduce the right trade "measures" at the right time. It is understandably right to put up regulatory bodies to be in charge of licensing, regulating, judicial arbitration, enforcing and enhancing standards among other things in a specific service sector. The need to have strong regulatory bodies "to ensure that private sector activity in the health system generates the expected benefits"[115] is a very vital role. This role must be very clear to all and sundry in the specific service sector.
It will make an unholy mix when a regulatory body engages itself with the provision of the service it is regulating. A ministry of health should not, nay, must not, regulate and at the same time offer the same services it is regulating. A conflict of roles and interest will always emerge. Where a ministry of health or government department of health exists and executes its role as a regulator the assumption is that *many* responsible investors in the sector are at play and need to be managed in an impartial way. It is hence important to ***have the regulator first*** to manage the new investors coming in a liberalised market in an impartial way. It is more important to have an ***independent regulator*** who is regulating and not offering the same service at the same time. He may regulate the service to his advantage.
Developing countries should seek more time using the above rationale to establish such regulatory bodies first in order to safeguard public health sector from unwarranted interference. The fore going statements need not be construed to mean a call for developing countries governments to cease to regulate or even provide healthcare services where necessary. It is meant to highlight the complexity of the problem that developing countries may encounter.
Alternatively GATS should have such clauses that mandates establishment of functioning ***independent regulatory bodies first*** before further liberalisation in the specific service sector to safe guard both the interests of liberalising country and the service providers.
Having emphasised the need to have functioning independent regulatory bodies first, before the actual process of liberalisation of service sectors, it is important to state that this is not all. Nations that are signatories to ICESCR are obligated "to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right health of others"[116]. This violation may occur where we have weak regulatory enforcement agency whereby "there is a risk that suppliers will compromise efforts to achieve equity in access or financing, or engage in consumer fraud"[117]. Governments of the day must ensure that such a body has teeth.

(b) Assessment of the service sector

Before further commitment is made in the existing commitments, assessment must be done to have a strong basis for either further commitment or withdrawal of any commitment so far. It is even much prudent to have research done to establish whether possible new commitments in whatever service sector will be beneficial to a country. Many countries assume that ***mode three*** or even ***mode four*** aspect of trade in services will automatically lead to an increased economic

[115] See paragraph 29 of Executive summary in the WTO AGREEMENTS &PUBLIC HEALTH, A joint study by the WHO and the WTO Secretariat.
[116] See Paragraph 31c of the Report of the High Commissioner. United Nations Economic and Social Council Document E/CN.4/Sub.2/2002/9
[117] Paragraph 237 of the WTO AGREEMENTS &PUBLIC HEALTH, A joint study by the WHO and the WTO Secretariat

advantage to the subscribing country. Such assumptions are dangerous if not backed with research. We must ask ourselves *how* we shall gain by committing ourselves in a certain specific service sector before we commit it in multilateral trading system.
The above not withstanding there is an urgent need for the Kenyan government to insist of knowing the status of what happened with the promise to "carry out an assessment of trade in services in overall terms and on sectoral basis "[118] by the Council for Trade in Services. On the basis of such an assessment, Kenya and other developing countries can be in a better position to know what to "request and offer"[119].

(c) Uniform professional standards

There is a need for creation of a clearinghouse for some of the healthcare professions qualification. A finding in the course of this study was that some countries seemingly do not have confidence with some healthcare professionals from Kenya. This is why complaints abound that some countries, particularly in the developed world, are not very confident that some developing countries' professionals are competent enough. Kenyans too have the same problem with some foreign countries healthcare system, whereby doubts linger on the quality of professional healthcare service administered there. GATS only says that "a member may recognize the education or experience obtained, requirements met, or licences or certifications granted in another country"[120]. It is not categorical that countries **must or shall** recognize "education or experience" obtained in another country. Hence, the call we make is for harmonisation globally of training, code of conduct, and administering of these services **first,** even before we think of globalised trading set-up. Lets come up with service professional standards "based on multilateral agreed criteria"[121] and this will make it easier for everyone to trade with one another. This is lacking as of now.

(d) Revisiting the schedule of commitments

Another approach that countries can employ, though rather complex and expensive, is revisiting the schedule of specific commitments. Once it is discovered that the existing 'specified terms, limitations, qualifications and conditions'[122] annexed to the commitment are not favourable to consumers of healthcare services in a country, this is one option. Governments "may modify or withdraw any commitment in its schedule"[123] if it sees necessary to do so, to accommodate new evolving developments that conflict with the broader and nobler needs of society. This, as noted earlier is too expensive and complex for such countries like Kenya. GATS ought to be structured such that in order to "modify or withdraw any commitment in its schedule", it should have clauses that empower developing countries to take unilateral measures to avert national crisis involving the specific committed service sector. The rule(s) should not be cumbersome neither expensive.

(e) Human rights should be supreme over trade rules.

The genesis of the current WTO affirmed at the conclusion of the Uruguay Round, through its membership, that the multilateral trade system was "for the benefit and welfare of their peoples"[124]. After all, what would be the need for "a fairer and open multilateral trading system"[125] if not to enable the people to enjoy "the right to the highest attainable standard of health" amongst other human rights, as a result of increased global trading. Trading in services, more specifically,

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[118] See GATS article xix. 3
[119] Paragraph 15 of Doha Ministerial Declaration, Doc. WT/MIN (01) DEC/1
[120] See GATS Article vii.1
[121] Ibid article vii.5
[122] See GATS Article xx.1 a&b
[123] See GATS Article XXI. 1a

[124] Marrakesh Declaration that ushered in WTO of 15 April 1994, paragraph 2
[125] Ibid.

trading in healthcare and health related services should be the least to interfere with a process intended to bring "benefit" or "welfare" to the people.
Therefore, where GATS supports, or encourages trampling of human right over basics needs such as the right to health, governments should ignore the agreement and let the human right be supreme.

From all the fore going its now clearer that trade in healthcare services need be handled with care it deserves. Some would rather let free trade reign or override all the pertinent issues raised in this research. Oblivious of the existing imbalances between developed and developing countries, in terms of economic empowerment, social and cultural development, merchants of healthcare services would prefer a multilateral setting in trade in this sector. This issue needs sober and open minded approach. The poor nations need help. They need not be loaded with programmes for compliance, or threats of "compensatory adjustments" on a most favoured nation basis to affected service providers. Service providers of different countries are at different levels of development. These facts must be taken into account for a fairer trade in services and more so, on health care services. Indeed "different service sectors require different policies and time frames for liberalization and some areas are better left under governmental authority"[126], and healthcare is one of them.

[126] Paragraph 39 of report of High Commissioner, United Nations Economic and Social Council Document E/CN.4/Sub.2/2002/9
25th June 2002

APPENDIX 1

POSSIBLE AREAS THE GOVERNMENT MAY REQUEST FOR MARKET ACCESS

	SECTOR	CORRESPONDING CPC	MARKETS	MODE	MEASURES SOUGHT
1.	**Construction Services**				
	• General construction work for building • General construction work for civil engineering • Installation and assembly work • Building completion & finishing work	512 513 514 & 516 517	Namibia, Botswana, Swaziland, South Africa, Lesotho, Namibia, Rwanda, DRC and other Comesa countries	3 & 4	• Recognition of professional qualifications and skilled labour • Elimination of Economic Needs Test • Elimination of trade distorting subsidies
2.	**Business Services**				
2.1	Architectural services	8671	Namibia, Botswana, Swaziland, South Africa and Comesa countries	1, 3 & 4	Recognition of professional qualifications
2.2	Engineering Services	8672	Lesotho, Namibia, Rwanda, DRC Ethiopia and Comesa countries		Recognition of professional qualifications
2.3	**Services provided by midwives, nurses, physiotherapists and paramedical personnel**	**93191**	**UK, USA, Australia, Canada, South Africa**	**3 & 4**	**Recognition of professional qualifications**
2.4	**Medical & dental services**	**9312**	**UK, USA, South Africa, Namibia, Swaziland & Lesotho**	**3 & 4**	**Recognition of professional qualifications**
2.5	Veterinary services	932	Sudan, Egypt, Ethiopia, Kuwait, Saudi Arabia, Zambia, Canada, America, UK, Botswana, Swaziland	3 & 4	Recognition of professional qualifications
2.6	Legal services	861	UK and Australia	3 & 4	Recognition of professional qualifications
2.7	Accounting, auditing and book-keeping services	862	Canada, USA, Australia, UK, Nigeria, Ghana, Rwanda, Burundi, Eritrea & Ethiopia	3 & 4	Recognition of professional qualifications
2.8	Research & Development Service on social sciences and humanities (Human Resource Consultancy)	852	Zambia, Ethiopia, Eritrea, Zimbabwe, Malawi	3 & 4	• Recognition of professional qualifications • Registration & licensing
2.9	(Other Business Services) Corporate Secretarial practice		Zimbabwe, Zambia, Mozambique, Botswana, Swaziland, Namibia, Canada,	3 & 4	• Recognition of professional qualifications • Registration & licensing

	SECTOR	CORRESPONDING CPC	MARKETS	MODE	MEASURES SOUGHT
			UK, Australia & India		
3.	**Educational Services**				
3.1	Secondary Educational Services	922	Mozambique, Botswana, Rwanda, Indonesia, Sudan, UK, Ethiopia & Eritrea	3 & 4	• Recognition of professional qualifications
3.2	Other educational services (Tertiary and University) Consultancy in Curriculum development, quality assurance controls and income generating projects	92.9	Mozambique, Botswana, Rwanda, Indonesia, Sudan, UK, Ethiopia & Eritrea	3 & 4	• Recognition of professional qualifications • Registration & licensing
4.	Other Services not included elsewhere • Ground Water Consultancy • Mineral Exploration		Sudan, Ethiopia, Botswana, Namibia, South Africa & DRC	3 & 4	• Recognition of professional qualifications
5.	**Financial Services**				
	• Life, accidental and health related services • Non-life insurance services • Services auxiliary to insurance	8121 8129 8140	Nigeria, Ghana, Saudi Arabia, Australia, UK, Canada, S. Africa, Swaziland, Namibia & Lesotho	3 & 4	• Recognition of professional qualifications • Registration & licensing
5.1	Reinsurance and retrocession	81299	"	1	
6.	**Requests to Tanzania and Uganda be pursued regionally in the framework of the EAC Co-operation**				

Sources: Ministry of Trade and Industries: Department of External Trade. June 2002

APPENDIX II

*Health Institutions and Hospital Beds and Cots by Province, 2000**						
	Health institutions				**Hospital Beds and Cots**	
Province	**Hospitals**	**Health Centres**	**Health sub centres and Dispensaries**	**Total**	**No. of Beds and Cots**	**No. per 100,000 Population**
Nairobi	55	51	375	481	4,703	20.0
Central	60	82	362	504	7,936	20.6
Coast	63	38	326	427	7,421	28.1
Eastern	62	77	686	825	7,112	14.7
North Eastern	6	9	61	76	1,610	13.6
Nyanza	95	111	324	530	1,041	22.6
Rift Valley	94	155	986	1,238	11,921	15.9
Western	65	88	187	340	6,336	18.0
Total 2001	500	611	3,310	4,421	57,540	18.9
Total 2002	**481**	**601**	**3,273**	**4,355**	**56,416**	**19.1**

Source: Government of Kenya Economic survey 2002 Page 45
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Bibliography

Ellen Gould and Clare Joy, *In whose service?* The threat posed by the General Agreement on Trade in Services to economic development in the South. World Development Movement Report (December 2000)

Government of Kenya, Ministry of Health, *Kenya's Health Policy Frame*work, November 1994

John Hilary, *The wrong model*, GATS, trade liberalisation and children's right to health (2001).

Kenya at the Crossroads, scenarios for our future. Institute of Economic Affairs, Society for International Development, 2001

Matthew Sanger, *Reckless Abandon:* Canada, the GATS and the future of Health Care (2001).

Republic of Kenya*, Economic Survey 2002*, copyright Central Bureau of Statistics 2002

Republic of Kenya, Ministry of Finance and Planning, *Poverty Reduction Strategy Paper For the Period 2001-2004* September 2001

Republic of Kenya, *National Development Plan 2002- 2008* Effective management for sustainable economic growth and poverty reduction

Republic of Kenya, Office of the president, Department of Development Co-ordination *National Poverty Eradication Plan 1999-2015*, February 1999

Scott Sinclair, *GATS* how the World Trade Organisation's new "services" negotiations threaten democracy (2000)

United Nations Economic and Social Council, *Economic, Social and Cultural Rights*, Liberalisation of trade in services and human rights, Report of the High Commissioner. Document E/CN.4/Sub.2/2002/9, 25th June 2002

United Nations, *International Covenant on Economic, Social and Cultural Rights*.

WTO Secretariat, Trade in Services Division, *An Introduction to the GATS*, October 1999

World Trade Organisation/World Health Organisation, *WTO AGREEMENTS & PUBLIC HEALTH,* A joint study by the WHO and the WTO Secretariat, August 2002