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The ghosts of user fees past: Exploring accountability for victims of a 30-year economic policy mistake

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Abstract

Today, there is an unmistakable shift in international consensus away from private health financing, including the use of user fees toward public financing mechanisms (notably tax financing), to achieve universal health coverage (UHC). This is, however, much the same as an earlier consensus reached at the WHO"s World Health Assembly at Alma-Ata in 1978. When considering the full circle journey from Alma-Ata in 1978 to today's re-emerging support for UHC, it is worth taking stock and reflecting on how and why the international health community took this nearly three decade detour and how such misguided policies as user fees came to be so widely implemented during the intervening period. It is important for the international health community to ensure that steps are taken to compensate victims and determine accountability for those responsible. Victims of user fees suffered violations of their human right to health as enshrined in Universal Declaration, ICESCR, and a number of other human rights treaties, and yet still cannot avail themselves of remedies, such as those provided by international and regional human rights fora or the various United Nations treaty-monitoring bodies, and the responsible institutions and individuals have thus far remained unaccountable. This lack of accountability suggests a degree of impunity for international organizations and health economists dispensing with health policy advice. Such a lack of accountability should be noted with concern by the international health community as it increasingly relies on the advice and direction of health economists. Steps must be taken to provide survivors of user fees with compensation and hold those responsible to account.

Today, there is an unmistakable shift in international consensus away from health sector privatization and user fees toward public provision of universal health coverage (UHC) with tax-based financing.[1] As part of broader efforts to privatize health financing in recent decades, the issue of user fees, in which fees are charged to users of health services at the time of delivery, proved especially controversial. The newly emerging consensus against privatization generally, and against charging user fees in particular, was recently articulated in a September 2012 special issue of The Lancet on universal health coverage.[2] The shift was also underscored in the December 2012 adoption of a United Nations General Assembly resolution on affordable universal health care, which urged member states to develop health systems that avoid significant direct payments at the point of delivery.[3] In practice, this shift has been exemplified in recent years, as countries such as China, India, Brazil Mexico, Sri Lanka and others have rejected the privatization approach in favor of moving toward UHC.[4]

This new support for UHC comes nearly 30 years after roughly the same conclusions had been reached at the 1978 World Health Organization (WHO) conference in Alma-Ata, Kazakhstan, at which UN agencies

and health representatives of 134 countries and 64 organizations formally recognized access to health care as a human right. The revolutionary significance of this acknowledgement implied tremendous new obligations on all governments to therefore adopt policies that would make a basic package of publically financed primary health care (PHC) universally accessible, affordable, and more socially responsible. The Alma-Ata consensus reflected the then-almost universal acknowledgement of the importance of scaled-up investment in public health systems generally.

But the Alma-Ata consensus was reaching its apex of political support just months before the world was dramatically changed by the ascendance of neoliberal economic policies, as represented by the election of Prime Minister Margaret Thatcher in the UK in 1979 and President Ronald Reagan in the US in 1980. Having spent much of the 1970s building political support, groups of conservative foundations and think tanks that had been propagating free trade and free market ideas were finally able to get their ideas enacted into policy.[5] The Reagan and Thatcher governments led others in dramatically reforming the thrust of economic policy at the World Bank and other bilateral aid agencies, including on health policy.

Ironically, in the late 1970s, the World Bank had been influenced by the prevailing perspectives of the Alma-Ata Declaration, and its annual World Development Report (WDR) 1980 expressed the idea of health care as a universal human right and showed a strong commitment to primary health care. And like other major international institutions at the time, the World Bank actually warned in the WDR 1980 against introducing user fees for health, education, and water: "The use of prices and markets to allocate health care is generally not desirable."[6]

But just as the ambitious nature of the Alma-Ata vision of universal access for primary health care was becoming recognized, the US and UK brought in many new free market economists to the World Bank, which began to adopt the new conservative counter-narrative that was emerging in the 1980s. According to this narrative, public sector efficiency could be improved by privatizing the health sector and by introducing user fees, which in theory would raise the additional revenue necessary to make the health sector financially viable. Critics' warnings that poor people would be unable to afford these fees went unheeded.

Other international organizations influential on health policy, such as bilateral donor agencies like USAID and the UK Department for International Development as well as some UN agencies, are also responsible for the promotion of private health financing reforms, including user fees[7] However, this article focuses on the World Bank, not only because it was a leader at the forefront of promoting user fees and significantly influenced other international agencies that followed its lead, but also because of its particularly coercive approach to making implementation of user fees a binding condition on its loans to many poor and aid-dependent borrowing countries.[8]

Thirty years of user fees at the World Bank: From critic to advocate to critic again

The origins of this logic in favor of user fees first appeared within the World Bank in the 1981 report, "Accelerated Development in Sub-Saharan Africa."[9] Also known as the Berg Report after its author, the paper is considered an important turning point in World Bank thinking in the 1980s, as the organization moved away from the Keynesian economics which had dominated from the 1940s to the 1970s and towards the market-oriented approaches of neoliberalism. Instead of finding ways to try to finance PHC, the report called for private insurance schemes, charging user fees at public health clinics, reorganizations and layoffs of staff in public health systems, streamlining administrative procedures, liberalizing the pharmaceutical trade, and "contracting out" to private firms.[10]

In addition to Berg, other individuals played important roles in shifting World Bank thinking, such as the Princeton University neoclassical economist David de Ferranti. Although today De Ferranti is an advocate for UHC, he was the author of 10 key papers for the Health Nutrition and Population unit at the World Bank between 1981 and 1985, which played an important role in introducing neoclassical economic principles such as "affordability" and "effectiveness" into health care decision making at the Bank.[11] In fact, de Ferranti's work proved particularly influential in the evolution of neoliberal thinking in health sector reform at the World Bank. For example, he defines affordability along the lines of the voluntarism and equilibrium inherent in neoclassical eco-

nomics, explaining "a health program is affordable if and only if each of the parties that must contribute to financing its operation at its design scale are able and willing to do so … [and] affordability is a necessary condition for achieving an efficient balance of resource use."[12] This was in sharp contrast to the Alma-Ata recognition that some parties (that is, poor patients) are too poor to contribute to the financing, and instead introduces the suggestion that they ought to pay.

Although de Ferranti warned of the looming gap in available resources for health programs, neither he nor Berg—ever proposed any ways to mobilize greater public expenditures. Instead, de Ferranti only suggested policy adjustments that would restrain the public sectors role in health care while increasing non-fiscal resources, such as charging user fees. Instead of the Alma-Ata view of health care as a human right—in which government policy is obligated to fulfill—the paper's logic depoliticized and negated the state's obligation to this commitment. Rather than exploring ways the state could fulfill this obligation, de Ferranti inverted the perspective to instead ask only how much health care could be afforded "subject to the resource constraint." As this new logic took hold throughout the World Bank and other aid donors, the earlier high-profile commitments to the Alma-Ata principles of access to health as a human right, which included support of the public health provision of PHC, were abandoned rapidly.

De Ferranti reflected this turning point in 1985 in another influential policy paper, "Paying for health services in developing countries: an overview."[13] This paper inverted the earlier World Bank view that prices and market allocations for health care were "generally not desirable" with the new official view that prices and market allocations are highly desirable and the best route to improving the efficiency of health care. The paper drew on the basic neoclassical proposition that efficiency is maximized by competitive market prices, which equal the marginal private cost of production. According to Stein, the paper attempted to delimit the circumstances in which marginal cost prices are relaxed such that health care is allocated in line with the principles of market efficiency.[14] The paper also suggested that user fees should approach the marginal cost of production for efficiency purposes, and that they are better for the poor since they provide improvements on the supply side. Concerns about the ability of poor people to pay user fees were not adequately addressed.[15]

The 1985 paper also undermined the Alma-Ata recognition of the importance of preventative care services by suggesting that people inherently have all the medical information they need concerning their health status, and that they will seek medical care "when an illness or injury occurs" This suggestion incorrectly presumed that symptoms are universally understood, unambiguous, or unaffected by weighing the potential opportunity costs of seeking medical care.

The idea that individual "health consumers," who rationally base every purchasing decision on how best to optimize their cost efficiency, ought to "purchase" health services only when they have begun to show symptoms—and not before—was more than just a convenient cost-cutting measure. It was arguably the kind of lethal reasoning that contributed to weakening the initial public health response to the HIV/AIDS crisis, possibly making the epidemic far worse than it otherwise would have been. For example, in considering exceptions to setting user fees equal to the marginal cost of patient specific services, the 1985 de Ferranti paper argued that external factors in the transmission of infectious diseases provided a high level of justification for "subsidizing" fees. This applied only to preventive services like vaccinations, however, because with regard to curative services, "it is doubtful whether any reduction in transmission probabilities is achieved … available technologies for treatment … rarely can be made effective before diseased individuals already have had maximal infections impact on others around them." According to Stein, this is precisely the kind of flawed reasoning that led to the imposition of user fees in STD clinics in places like Kenya in the early 1990s.[16] These fees lowered attendance rates at the worst possible time: the early stages of the HIV/AIDS epidemic in Africa.

The 1985 paper also made a strong push for general privatization of health care, claiming that the role of the private sector is "a key one." While admitting that the evidence on private provision was so far inconclusive at the time, he still proposed a plan to foster the development of private institutions, in which the basic idea is to limit the growth of the public sector until the private sector can take over. Privatization, along with defunding the public health system, is justified because if one can charge full-cost marginal pricing for patient care, then "for patient related

services … the arguments in favor of a strong public role in the provision of health care are, on close inspection, not very compelling."[17]

In 1987, de Ferranti co-authored a World Bank paper with Nancy Birdsall and John Akin, "Financing health services in developing countries," which promoted private health financing over public mechanisms, provided the main thrust for including user fees in health as a loan condition within structural adjustment loans, and placed a heavy emphasis on government decentralization reforms within the health sector.[18] Decentralization is appealing to both political progressives, who wish to strengthen community participation by devolving power and accountability to the local levels of government, and to neoliberal economists, who seek to transform it into a "market-like" process by which citizens become "customers" of services that the local government is "selling."[19] According to the authors, the key to successful decentralization of the government health system is to "use market incentives where possible" and encourage the collection of revenues "as close as possible to the point of service."[20] In such a process, the traditional benefits of being connected to the cross-subsidization and redistributive benefits of national tax-based financing become disconnected. Instead, more of the direct costs are placed on local governments and individual citizens, who have been transformed from citizens with a right to health into individually paying customers, in accordance with the neoliberal vision of going market rates.

By 1987, these papers proved influential in establishing new World Bank health sector reform policies, helping to completely invert the Bank's earlier position—as stated in its 1975 Health Sector Policy and 1980 WDR reports—as the use of prices and markets to allocate health went from undesirable to highly desirable. By the mid-1980s, all of the intellectual pieces needed to justify the allocation of health care via the market with World Bank policy advice and loan conditions were in place; these became a key part of structural adjustment programs, particularly throughout the 1990s. By 1993, the Bank published its first health-focused WDR, "Investing in health." which laid out the neoliberal agenda of user fees, privatization, and decentralization of government services.

During the 1980s, the world of Keynesian economics that prevailed from the 1940s through the 1970s was completely overturned in favor of neoliberal ideas of free trade and free markets, and the notion that prices and interest rates should be determined by markets. With structural adjustment programs, the World Bank and IMF offered new loans to heavily indebted developing countries, conditional on compliance with a set of economic policy reforms. These loan conditions often required that inflation and fiscal deficits be kept at very low levels and that when it comes to the government's role in finance, trade, and industrial policies, the state should privatize, deregulate, and withdraw. These neoliberal policy reforms then influenced other major foreign aid donors and the prevailing international thinking in several policy areas, including health sector reform. These changes greatly transformed the health sectors of dozens of developing countries as deep budget cuts, staff layoffs, and user fees were applied throughout the 1980s and 1990s; this had tragic consequences for millions of people who were too poor to afford the user fees.

Under mounting pressure from civil society critics, the US Congress approved legislation in 2000 that prevented the US Treasury from approving any further World Bank loans with user fees included as binding conditions. This compelled the World Bank to issue a revised user fees policy in 2001, in which it acknowledged that the fees have prevented poor people from accessing health clinics (and primary education), and stating it now "opposes user fees for primary education and basic health services for poor people." However, it included a caveat that said it would still support user fees in some circumstances.[21] The World Bank eventually removed its blanket policy on user fees in the WDR 2004 and its HNP policy in 2007, yet despite the revision of user fees policies across UN institutions, the Bank still promotes them in some cases, and user fees remain common in many developing countries.

Wrong economic policies prove deadly

The disastrous consequences of the 30-year neoliberal policy experiment conducted on the health care systems of developing and transition economies are well-documented.[22] The related harmful consequences of premature decentralization and charging of user fees are similarly well-documented.[23]

The 2008 World Health Report summed up the overall experience with user fees, documenting how many countries introduced them in the 1980s and 1990s

in an effort to infuse new resources into struggling services, often in a context of disengagement of the state and dwindling public resources for health. WHO noted in the report: "Most undertook these measures without anticipating the extent of the damage they would do." In many settings, "dramatic declines in service use ensued, particularly among vulnerable groups, while the frequency of catastrophic expenditure increased." The WHO report also noted, "Where some countries have reconsidered their position and started phasing out user fees, this has resulted in substantial increases in the use of services, especially by the poor."[24],[25]

The 2010 World Health Report documented widespread "financial catastrophe (for households) associated with direct payments for health services" and states that "even when relatively low, any kind of charge imposed directly on households may discourage using health care services or push people close to poverty under the poverty line." The 2010 WHO report found that when people have no choice but to use services, they may incur high—sometimes catastrophic—costs from which they never recover. Taken together, WHO estimated that around 150 million people suffer financial catastrophe annually, while 100 million are pushed below the poverty line. WHO Director Margaret Chan has said that user fees represent "by far the greatest obstacle to progress" toward achieving universal coverage.

Médecins Sans Frontières (MSF) collected case studies that highlight the consequences for those who had to pay user fees: Mayo-Kebbi, the head of Midikil village in Chad, explained to MSF in 2006, "During the rainy season we have no money and the food stocks are empty. We don't have any means to pay for care at the health centre and children die." [26]

A woman in Bujumbura, Burundi explained in 2003:

> I was very worried and I brought my little girl to the health centre in my district in the south of Bujumbura. But the nurse wouldn't see us, as I didn't have any money to pay for the consultation. So I had to take my girl back home without having received any care. Then I had no choice but to borrow 2000F (US$1.34) from my neighbors for the consultation. I also bought a few medicines on the black market. Every day I pay back 150F (US$0.17) of the 250F (US$0.29) that I earn carrying bags. I have 100F (US$0.11) left over to feed my family. It's not a lot.[27]

And one member of a focus group in Makeni hospital in Sierra Leone explained, "We normally do not go to the clinics at the time we are supposed to because of the cost of services and we don't have money all the time."[28]

In contrast to the untested economic theories of the World Bank's health economists in the 1980s, it turns out the critics had been correct all along: user fees do not raise substantial revenue for the health sector, nor do they make public health interventions more effective. Rather, they turned out to be inequitable and sharply limited access to health care for the poor. The surges in demand whenever the fees are abolished suggests that the neoliberal premises upon which user fees were based do not hold true. The surges suggest that people actually do place tremendous value on health care services, and that the value has absolutely nothing to do with the going free market prices. Coming full circle back to the earlier consensus arrived at in Alma-Ata, today's emerging consensus supports removing user fees as a way to increase health care utilization and improve health outcomes for the poor.

The quest for accountability

When considering the full circle journey from the Alma-Ata consensus in support of tax-financed, public PHC in 1978 to today's reemerging support for tax-financed, public UHC, it is worth asking how and why the international health community took this nearly three decade detour and how such a misguided alternative policy could have dominated during the intervening period. More importantly, there are related questions of accountability and liability, and determining who is responsible for the tragedy. Trying to quantify the exact degree of criminally negligent homicide resulting from such economic policies is difficult to ascertain. For example, James et al. projects that 153,000 child deaths could be avoided if user fees were abolished in 20 African countries.[29] However, Yates looked back in time and raised perhaps even more important questions, estimating that 3 million child deaths could have been averted had user fees not been charged.[30]

It is important to ask if the surviving victims of the negligent policies will get any recompense, or if there will be any accountability for the purveyors of the policies, such as the World Bank and/or its economists. While precise quantification of the death and injury resulting from the implementation of user fees may not be possible, the degree of pain and suffering as a consequence of the policy is undeniable and considerable in magnitude; someone holds responsibility for the unnecessary nature of these injuries.

In criminal law, criminal negligence is defined as an act that is careless, inattentive, neglectful, willfully blind, or in the case of gross negligence, what would have been reckless in any other defendant. Arguably, the World Bank exhibited such negligence because the implementation of user fees was like a grand ideological experiment on millions of unwilling subjects, whereas a proper approach to analyzing the effect of user fees would have been to first observe the outcome in small controlled studies, with subjects who have given their prior and informed consent. But this was never done before the World Bank mandated user fees as binding loan conditions across dozens of poor and aid-dependent countries in a blanket manner.[31]

Over time, legal advocates have expanded the frontiers of liability for injustices, with many countries adopting far-reaching legal codes for criminal malpractice lawsuits, particularly for legal and medical malpractice cases. Increasingly, victims can seek redress from negligent doctors and lawyers, who can be faced with serious civil and criminal liabilities. Pharmaceutical companies, too, are increasingly held liable and threatened with litigation in cases of gross negligence when they have marketed medicines that turn out to be unsafe.

It is noteworthy that while the legal and medical professions can decertify and disbar doctors and lawyers for malpractice, the economics profession has never established a process for sanctions against economists who get it wrong.[32],[33] For example, former US Federal Reserve Chairman Alan Greenspan conceded to the US Congress that his belief in the economic theory that claimed self-interest would prevent private investors from over-leveraging themselves "was wrong," and that therefore the under-regulation of financial markets he was responsible for regulating was also wrong.[34] Yet neither Mr. Greenspan nor his economists faced any civil or criminal liabilities or other sanction, despite the clear damage done to millions of people from the near financial collapse and ensuing recession.

Similarly, former US President Bill Clinton conceded to a US Senate committee that his administration's policy of using USAID and World Bank loan conditions to force trade liberalization in Haiti "was wrong". Although it allowed more US produced rice to enter its economy, the trade policy reform wiped out domestic small rice farmers and undermined Haiti's food security.[35] Neither Mr. Clinton nor his economists faced any civil and criminal liabilities or other sanction, despite the lives that were undeniably harmed.

In light of this lack of accountability in the economics profession, a group of US economists has been leading an effort to pressure the American Economic Association to formally adopt a code of ethics as a first step towards greater accountability.[36] Such a code would compel economists to disclose their financial affiliations with firms when giving public advice on economic policy. Yet the code of ethics is only a first step towards developing greater degrees of sanctions for professional malpractice.

Legal advocates have been pushing the frontiers of legal liability in other arenas, however. Interesting steps forward have been achieved with the establishment of the International Criminal Court (ICC) to hold individuals accountable for human rights abuses and crimes against humanity across international boundaries. The United Nations Working Group on the issue of human rights and transnational corporations and other business enterprises, and civil society advocates, such as Earthrights International, have been pursuing the boundaries of accountability for enabling local populations to seek redress for environmental or other human rights abuses committed by multinational companies in their overseas operations. However, attempts to sue international organizations such as the World Bank have proven difficult.[37]

As a specialized agency of the United Nations, the World Bank has signed a relationship agreement with the United Nations which states that, while it should consult with and be respectful of the United Nations, it is not bound to comply with any UN instructions, with the exception of Article VII resolutions of the Security Council.[38]

It has been argued that the United Nations Declaration of Human Rights (UNDHR), while not a binding treaty, is beginning to take on the characteristics of "customary international law" to which the World Bank is subject under the Vienna Convention.[39,40] This suggests that the UNDHR would impose on the World Bank an obligation to respect, protect, and fulfill human rights.[41] However, holding the World Bank accountable under international law is difficult.[42] Although its status as a subject of international law is clear, its substantive rights and responsibilities are not as clear as those of individual states. This anomalous position has enabled the World Bank to contend that many international legal obligations found in customary law do not apply to the organization, and that it is not bound by treaties to which it is not a signatory. The result is that to date, de facto international law has imposed few constraints on Bank operations. International lawyers have yet to fully explore or rigorously analyze this "accountability gap"; the rights, responsibilities, powers, and obligations of the Bank are not settled and need greater elaboration.[43]

The Tilburg Guiding Principles on World Bank, IMF and Human Rights, drafted by experts at Tilburg University in 2001 and 2002, attempted to link legal obligations in the field of human rights to the organizations' obligations and discussed the possible redress of adverse human rights impacts of their activities. The sixth Tilburg Guiding Principle notes that despite the fact that their relationship agreements with the UN allow the IMF and World Bank to function as independent international organizations, these only provide an organizational independence from the UN—*not from international law."*[44]

Although the World Bank eventually changed its policy on user fees, it has not yet assumed any responsibility for reparations. One way to resolve the "accountability gap" is to strengthen and clarify the applicability of international law rules to the World Bank as a subject of international law with an attempted lawsuit on behalf of those harmed by Bank actions. Such a step would necessarily help clarify the responsibilities of the World Bank and other IFIs under international law.

Despite the independence from the UN provided for in its relationship agreement, the Bank remains part of the UN system and the degree of independence does not, as Tilburg Guiding Principles note, discharge the Bank from its obligations under international law as contained in the United Nations Charter.[45] For example, as a specialized agency, the World Bank is still obligated to further the objectives of the UN Charter and not to take actions that undermine those objectives.[46] This requirement is laid out in Article 59 of the Charter, which mandates that "the creation of any new specialized agencies require[s] accomplishment of the purposes set forth in Article 55."[47] The purposes and objectives articulated in Article 55 include, inter alia, the promotion of "universal respect for, and observance of, human rights and fundamental freedoms for all."[48]

Furthermore, Article 103 of the UN Charter makes clear that "in the event of a conflict between the obligations of the Members of the United Nations under the present Charter and their obligations under any other international agreement, their obligations under the present Charter shall prevail."[49] However, because World Bank loans and their conditions arguably fall under the category of "any other international agreement," they ought to have been subordinated to the obligations of the UN Charter. But in the conflict between the World Bank's user fees conditions and the UN Charter—and the human right to health therein—the user fees loan conditions prevailed and were not subordinated, thus constituting a violation of Article 103 of the UN Charter.

The question of gross negligence arises because it is arguable that the World Bank knew or should have known that its user fees policy was violating the right to health. By not intervening and continuing its financial and technical support and loan conditions for the implementation of user fees until at least 2004, the World Bank, along with its member states, is complicit in those human rights violations that occurred during this time, and violated the legal obligations enshrined in, inter alia, the UN Charter to promote universal respect for, and observance of, human rights.

Despite the fact that the World Bank is so obligated, its Articles of Agreement are filled with immunity clauses which attempt to make legal efforts holding the Bank accountable for its actions a virtual landmine of procedural obstacles, including the legal concept of "functional privileges and immunities." For example, its Article VII on Status, Immunities and Privileges, states in Section 1 (Purposes of the Article) that: "To enable the Bank to fulfill the func-

tions with which it is entrusted, the status, immunities and privileges set forth in this Article shall be accorded to the Bank in the territories of each member." Section 8 (on "Immunities and Privileges of Officers and Employees") provides that "[a]ll governors, executive directors, alternates, officers and employees of the Bank (i) shall be immune from legal process with respect to acts performed by them in their official capacity except when the Bank waives this immunity…." However, Section 3 (Position of the Bank with Regard to Judicial Process) notes that "[a]ctions may be brought against the Bank only in a court of competent jurisdiction in the territories of a member in which the Bank has an office, has appointed an agent for the purpose of accepting service or notice of process, or has issued or guaranteed securities." This clause in Section 3 of its Article VII may allow for legal action against the World Bank if the case of user fees is considered.

Additionally, another avenue of argumentation notes that the member states that make up the World Bank all have human rights obligations. These states cannot ignore, or indeed violate, these obligations simply by organizing themselves into the World Bank or by using the bank as an agent to carry out policies that violate their respective international human rights obligations. Therefore, arguably each member state of the World Bank has engaged in violating their respective human rights legal obligations to respect, protect, and fulfill the human right to health. States should not be allowed to simply violate their respective human rights obligations through the formation of corporations or inter-governmental organizations or agencies that are then used as agents of those states to implement policies that violate their respective international or domestic legal obligations.[50]

This approach to the liability of individual member states of the World Bank is also relevant because most members are among the 160 countries which have made concrete obligations to ensure the realization of economic, social and cultural rights, with such obligations enshrined in the Universal Declaration of Human Rights and in a number of other human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR). As part of such obligations, parties to the ICESCR and other treaties have committed themselves to achieving progressively the full realization of these rights by using the "maximum of available resources." Although the ICESCR did not specify exactly what using the maximum available resources means in practice, several UN Special Rapporteurs and Independent Experts have attempted to more precisely define certain economic policies that are important for supporting the Covenant's key principles of "progressive realization" of rights and the avoidance of "retrogression" on fulfilling such rights for citizens.[51] States' actions taken at the World Bank to promote private financing including user fees have led to outcomes that would constitute violations of the obligations to pursue progressive realization of the human right to health and avoid retrogression in the realization of this right.

Furthermore, according to the United Nations Committee on Economic, Social and Cultural Rights, under international human rights laws and principles, the World Bank is obligated to pay reparations for human rights abuses it may commit:

> International agencies should scrupulously avoid involvement in projects which, for example... promote or reinforce discrimination against individuals or groups contrary to the provisions of the Covenant [on Economic, Social and Cultural Rights]...Every effort should be made, at each phase of a development project, to ensure that the rights contained in the Covenant are duly taken into account.

Yet in the case of user fees in World Bank loan conditions, the human right to health was not taken into account.

Despite the violations of the human right to health by the World Bank and its member states, the fact that survivors of such violations cannot yet avail themselves of remedies, such as those provided by international and regional human rights fora or the various United Nations treaty-monitoring bodies, suggests a degree of impunity for international agencies dispensing with health policy advice that should be noted with concern by the international health community.

As a lending agency, the World Bank has a duty to ensure that its projects, loan conditions, and policy advice are implemented in such a way that does not result in the violation of human rights, such as the right to heath. Nevertheless, the Bank breached this

duty by ignoring the human rights violations which occurred in the context of the implementation of user fees and therefore could be liable. This liability should be explored further by civil society advocates and foundations by bringing together survivors of user fees with international lawyers to consider avenues for bringing a class action lawsuit against the World Bank.

Conclusion

The new consensus towards UHC suggests that an evidence-based approach to policy may finally be prevailing over an ideologically driven approach. While the new consensus shifting in favor of UHC is to be welcomed, the international health community cannot dismiss the unnecessary suffering and harm caused by the reckless adoption of ideologically driven user fees policies over the last 30 years. It is incumbent on the international health community to reflect and take stock of what went so badly wrong that led to the widespread application of user fees in the world's poorest countries and take steps to determine accountability for those responsible. As we welcome the new consensus, the past victims of user fees must have their voices heard and all potential avenues for compensation must be fully pursued. More broadly, the current lack of accountability and liability in the economics profession should be of concern to the international health community as it increasingly relies on the advice and direction of health economists.

References

1. PMAC, "Bangkok Statement on Universal Health Coverage," Prince Mahidol Award Conference 2012, "Moving Towards Universal Health Coverage: Health Financing Matters"(Bangkok, Thailand: January 28, 2012); Y. Huang, "World momentum builds for universal health coverage: Despite recession, emerging economies follow Europe's lead, striving for universal health coverage," *Yale Global* (The Yale Center for the Study of Globalization, March 9. 2012); World Health Organization, *The world health report, 2010: Health systems financing the path to universal coverage* (Geneva: WHO, 2010); R. Yates, "Universal health care and the removal of user fees," The Lancet 374/9690 (2009), p. 608; L. Garrett, A. M. Chowdhury, and A. Pablos-Méndez, "All for universal health coverage," *Lancet* 374/9697 (2009), pp. 1295-1299.

2. "Universal Health Coverage: Themed issue," *Lancet*, 380/9845 (2012).

3. M. Tran, "UN adopts 'momentous' resolution on universal healthcare: General assembly urges countries to launch affordable healthcare systems that cover all their citizens," *The Guardian* (December 13, 2012).

4. W. C. Yip, W. C. Hsiao, W. Chen, et al., "Early appraisal of China's huge and complex health-care reforms," *Lancet* 379/9818 (2012), pp. 833-842; K. Sinha, "Free medicines for all from October" Times of India June 23, 2012; WHO "Brazil"s march towards universal coverage," *Bulletin of the World Health Organization* 88/9 (2010); M. Wallengren, "Mexico to have universal healthcare by year's end: minister" *Xinhua* (November 4, 2011); P. Rannan-Eliya, P. Ravi, and L. Sikurajapathy "Sri Lanka – 'Good practice' in expanding health care coverage." *Research Studies Series* 3 (Colombo: Institute for Health Policy, 2008).

5. S. George, "How to win the war of ideas: lessons from the Gramscian right," *Dissent*, Summer (1997).

6. World Bank, *World development report* (Washington, DC: World Bank, 1980).

7. K. Lee and H. Goodman, "Global policy networks: The propagation of health care financing reforms since the 1980s" in K. K. Buse, and S. F. Lee, eds., *Health policy in a globalizing world* (Cambridge: Cambridge University Press. 2002); World Bank and WHO, *World development report 1993: Investing in Health* (New York: Oxford University Press, 1993); World Bank and United Nations Development Programme. *Africa's adjustment and growth in the 1980s: A joint World Bank-UNDP Publication* (Washington DC: World Bank, 1989); Department for International Development (DFID), *Making governments work for poor people* (London: DFID, 2001).

8. OED, *Investing in health: Development effectiveness in the health, nutrition, and population sector* (Washington DC: World Bank Operations Evaluation Department, 1999); M. Whitehead., G. Dahlgren, and T. Evans, "Equity and health sector reforms: can low-income countries escape the medical poverty trap?" *Lancet* 358/9284 (2001), p. 833; K. Sen and M. Koivusalo, "Health care reforms and developing countries—a critical overview," *International Journal of Health Planning and Management* 13 (1998), pp. 199–215.

9. World Bank, *Accelerated development in Sub-Saharan Africa* (Washington, DC: World Bank, 1981).

10. Ibid.

11. S. Boseley, "From user fees to universal healthcare - a 30-year journey," Sarah Boseley's Global Health Blog, *The Guardian* (October 1, 2012).

12. N. Prescott and D. de Ferranti, "The analysis and assessment of health programs," *Social Science*

and Medicine 20/12 (1985), pp. 1235–40.
13. D. de Ferranti, "Paying for health services in developing countries: an overview," World Bank Staff Working Paper no. 721 (Washington, DC: World Bank, 1985).
14. H. Stein, "Beyond the World Bank agenda: An institutional approach to development" (Chicago, IL, and London: University of Chicago Press, 2008).
15. Ibid.
16. Ibid.
17. De Ferranti (see note 9).
18. World Bank, *Financing health services in developing countries* (Washington, DC: World Bank, 1987).
19. Ibid.
20. Ibid.
21. U.S. Civil Society Coalition, "Responsible reform of the World Bank: The role of the United States in improving the development effectiveness of World Bank operations," (April 2002).
22. UNICEF, *The state of the world's children* (Oxford and New York: United Nations Children's Fund, 1993); UNICEF, *The state of the world's children* (Oxford and New York: United Nations Children's Fund, 1994); Costello, A. et al. (1994) "Human Face or Human Façade? Adjustment and the Health of Mothers and Children," London: Centre for International Child Health, University of London; Evans, I. (1995) "SAPping maternal health," *Lancet*, Vol. 346, No. 8982, p. 1046; P. Lurie, P. Hintzen, and R. A. Lowe, "Socioeconomic obstacles to HIV prevention and treatment in developing countries: The roles of the International Monetary Fund and the World Bank," *AIDS* 9/6 (1995), pp. 539–46; B. Schoepf, "Theoretical therapies, remote remedies: SAPs and the political ecology of poverty in health in Africa," in J. Kim, J. Mullen, A. Irwin, J. Gershman (eds.), *Dying for growth: Global inequality and the health of the poor*, (Monroe, ME: Common Courage Press, 2000); M. Fort, M.A. Mercer, O. Gish, S. Gloyd (eds.), *Sickness and wealth: The corporate assault on global health* (Cambridge: South End Press, 2004); G. Cornia, S. Rosignoli, L. Tiberti, (2008) "Globalisation and health, 1980–2000: pathways of impact and initial evidence," Paper presented at a November 2006 meeting of the Globalization Knowledge Network of the WHO Commission on the Social Determinants of Health, Gauteng, South Africa; V. Navarro, *Neoliberalism, Globalization and Inequalities: Consequences for health and quality of life* (Amityville, NY: Baywood Publishing, 2007).
23. C. Collins and A. Green, "Decentralization and primary health care: some negative implications in developing countries," *International Journal of Health Services* 24/3 (1994), pp. 459–75; DFID "The case for abolition of user fees for primary health services: abolishing user fees for health care could help the poor – but extra funding needed" (London: Health Systems Resource Centre, Department for International Development, 2004); WHO World health report 2008: *Primary health care now more than ever* (Geneva: World Health Organization, 2008); MSF "No cash, no care: how 'user fees' endanger health; an MSF briefing on financial barriers to healthcare" (Médecins sans Frontières, March 2008); M. Lagarde and N. Palmer, "The impact of user fees on access to health services in low- and middle-income countries," *Cochrane Database of Systematic Reviews*, Issue 4. Art. No.: CD009094. DOI: 10.1002/14651858.CD009094.
24. WHO (see note 23).
25. EQUINET, "Reclaiming the resources for health: A regional analysis of equity in health in East and Southern Africa," (Kampala: Regional Network on Equity in Health in Southern Africa (EQUINET), 2007.
26. MSF, "No cash, no care: how 'user fees' endanger health; an MSF briefing on financial barriers to healthcare" (Médecins sans Frontières, March 2008).
27. Ibid.
28. Ibid.
29. C. James, S. S. Morris, R. Keith, and A. Taylor, "Impact on child mortality of removing user fees: Simulation model," *British Medical Journal* 331 (2005), pp. 747–49.
30. Yates, 2009 (see note 1).
31. Stein, 2008 (see note 14).
32. G. F. DeMartino, *The Economist's oath: On the need for and content of professional economic ethics* (New York, Oxford University Press, 2011).
33. J. Carrick-Hagenbarth and G. Epstein, "Dangerous interconnectedness: economists' conflicts of interest, ideology and financial crisis," *Cambridge Journal of Economics* 36 (2012), pp. 43–63.
34. E. Andrews, "Greenspan concedes error on regulation," *The New York Times* (October 23, 2008).
35. J. Katz, "With cheap food imports, Haiti can't feed itself," *The Washington Post* (March 20, 2010).
36. S. Chan, "Letter calls on economists to adopt code of ethics," *The New York Times* (January 4, 2011).
37. B. Thiele and M. Gómez, "Suing The World Bank: The Chixoy Dam Case," in J. Squires (ed.), *The road to a remedy: Current issues in the litigation of economic, social and cultural rights* (Sydney: Australian Human Rights Centre and UNSW Press, 2005).
38. Agreement between the United Nations and the International Bank for Reconstruction and

Development, 16 U.N.T.S., 1947, pp. 346 et seq, at art. IV, § 3; See also, "Agreement between the United Nations and the International Bank for Reconstruction and Development, Approved by the General Assembly on November 15, 1947," *International Organization*, Vol. 2, No. 1, February, p. 198.

39. United Nations General Assembly Resolution, General Assembly Resolution 217 A (III) (Universal Declaration of Human Rights) (10 Dec. 1948). Available at: www.ohchr.org/EN/UDHR/Pages/Introduction.aspx.

40. M. Darrow, *Between light and shadow: The World Bank, the International Monetary Fund and international human rights law* (Oxford & Portland, OR: Hart Publishing, 2003). See pp. 129–133 and sources cited therein.

41. D. Bradlow, "International law and the operations of the international financial institutions," in D. Bradlow and D. Hunter (eds.), *International financial institutions and international law* (Boston: Kluwer Press & Washington DC: American University, WCL Research Paper No. 2011-14, 2010).

42. D. Bradlow and D. Hunter, "Conclusion: The future of international law and international financial institutions," in D. Bradlow and D. Hunter (eds.), *International financial institutions and international law* (Boston: Kluwer Press & Washington DC: American University, WCL Research Paper No. 2011-14, 2010).

43. D. Renfrey, "World Bank, When will it be human rights first, articles of agreement second?" RightingFinance.org Blog Post (February 19, 2013). Available at http://www.rightingfinance.org/?p=308#comment-2503.

44. W. Van Genugten, "Tilburg guiding principles on World Bank, IMF and human rights," in W. Van Genugten, P. Hunt, and S. Mathews (eds.), *World Bank, IMF and Human Rights* (Nijmegen: Wolf Legal Publishers, 2003), pp. 247-255.

45. M. Darrow, (see note 40); S. Skogly, *The human rights obligations of the World Bank and the IMF* (London: Cavendish Publishing, 2001).

46. Ibid.

47. Ibid.

48. The Charter of the United Nations (adopted 26 June 1945, entered into force 24 October 1945), 59 Stat.1031, T.S. 993, 3 Bevans 1153.

49. Ibid.

50. Renfrey, D. (2013), see note 43.

51. R. Balakrishnan, D. Elson, J. Heintz, and N. Lusiani, "Maximum available resources and human rights: Analytical report," Center for Women"s Global Leadership (Rutgers, The State University of New Jersey, June 2011).