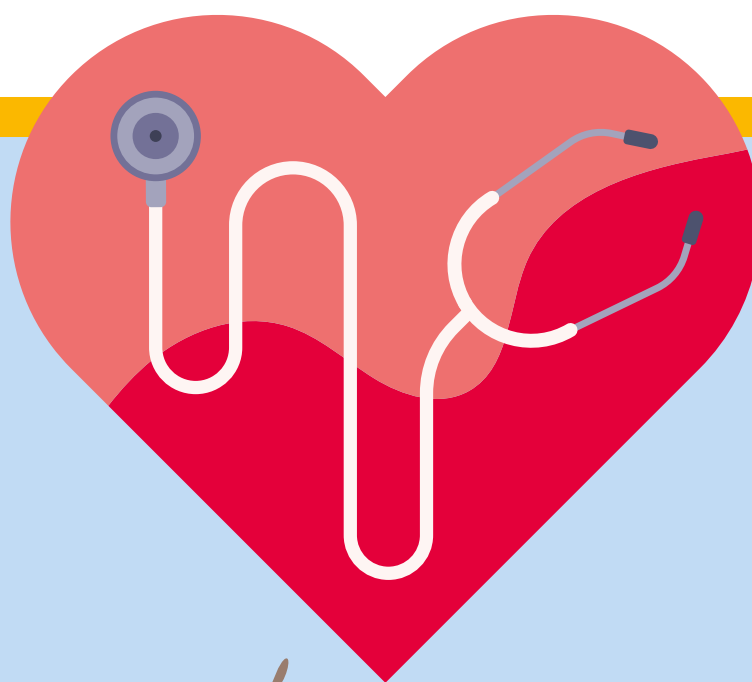
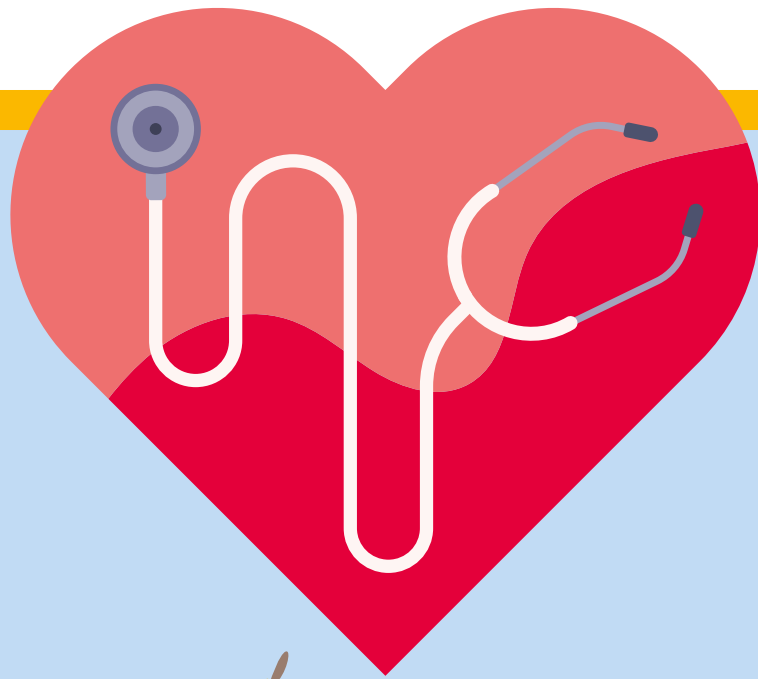


# Strengthening consumer protection in the provision of health services in the wake of the COVID-19 pandemic



United  
Nations

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**United  
Nations**

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## INTRODUCTION AND BACKGROUND

This report contributes to Phase 1 of the United Nations Social Protection Project - 2023Y: Strengthening Social Protection for Pandemic Responses: Identifying the Vulnerable, Aiding Recovery and Building Resilience.<sup>1</sup> The project fits within the United Nations Development Account – a capacity building programme of the United Nations secretariat, which aims at: “strengthening existing capacities and emerging gaps of core institutions responsible for the planning, design, and implementation of social protections systems, in order to ‘build back better’ as a response to COVID-19.” It takes inspiration from the words of the United Nations Secretary-General during the early days of the pandemic: “We simply cannot return to where we were before COVID-19 struck, with societies unnecessarily vulnerable to crisis. We need to build a better world.” (2 April 2020)

In this context, the role of health services is ever more obvious. Perhaps less obvious to many is the role, or potential role, of consumer protection in health. The policing and suppression of such practices as price manipulation of health products on the retail market, or of misleading advertisements for ‘miracle cures’ are known and have been widely applied by member States during the COVID-19 pandemic. This paper goes further and sets out a wider range of consumer protection practices that are applicable to health and draws the links between these two fields. Crucially, this exercise is set within the rapidly changing spectrum of social protection mechanisms of which health care is a major element. Such mechanisms include income support for those taken ill and those taken out of employment as a result of confinement measures and/or sharp economic contraction. Many of those people have serious problems as consumers as well as workers for reasons which impinge upon health.

This report does not evaluate the responses to COVID-19, but rather, identifies needs that have emerged and which, therefore, apply to possible future pandemics as well. The remaining phases of the current crisis may last longer in economic terms in low-income countries than in those with high-incomes. It takes into account the economic impact and the need to protect those people who work in the informal economy and who are consequently excluded from many social protection entitlements, including at times, affordable health care.

Further to statistics on morbidity and mortality related to the pandemic, the figures on poverty during the crisis make grim reading and, of course, are in a constant state of flux. Indeed, the estimates are worsening as the pandemic lasts. For example, the Committee for the Coordination of Statistical Activities (CCSA), has reported that the baseline calculation of the number of people living in “extreme poverty” (on less than \$1.90 per day) in 2020 increased from 614 million to 733 million, describing the 119 million increase as “the COVID-19 induced new poor.”<sup>2</sup> The World Bank has indicated that this is the first global increase in poverty since 1998.<sup>3</sup>

A recent project paper has reported that the increases in poverty are: “reversing a declining trend that lasted over two decades. Some 1.6 billion working in the informal sector could see their livelihoods at risk, and many lack access to any form of social protection.”<sup>4</sup> The link between health care and income support within the structure of social protection is reinforced by the policy brief from the Secretary-General of the United Nations in September 2021, which sets out these two dimensions, made up of “four guarantees” within a set of social protection mechanisms.<sup>5</sup>

If health policy is to respond adequately to the trajectory from health crisis to employment crisis, then another dimension of the economic impact is the shift from health crisis to consumer crisis. A survey presented in March 2020 by Consumers International, the global federation of consumer associations, put it as follows as early as April 2020: “COVID-19 is first and foremost a health crisis, but it could quickly become a financial crisis for many consumers. People who are unwell, caring for others or isolating may not be able to work, may have difficulty accessing financial services in the usual way and may be more vulnerable to fraud – all issues that have a direct impact on their personal finances.”<sup>6</sup> This prediction was all too accurate with particular salience in low-income countries.

This paper reports on measures taken by consumer protection agencies to protect consumers from bad practices, such as scams. It also identifies the need to make far reaching arrangements to deal with long term consumer commitments such as consumer credit repayments, rents, or home loans. These are discussed under measures relating to “force majeure”,

(sometimes known in insurance parlance as “Acts of God”). Management of the economic impact would be incomplete without consideration of the consumer dimension.

This report is meant to contribute to improving consumer protection in the provision of health services by exploring the scope for both operational and conceptual exchange. It covers representation and redress for consumers to improvement mechanisms for treating consumer grievances. It also addresses the interplay of different national agencies as well as that of international legal and institutional frameworks. Some considerations for a sectoral regulator are also being put forward.

The thesis presented here is that the two public policy areas of consumer protection and health face similar challenges. Consumer protection has previously focussed on retail transactions rather than on access to public services. This tendency is shifting as demonstrated by the inclusion of “access to essential services” in the United Nations Guidelines for Consumer Protection in 2015 (section 1.2). The United Nations Agenda 2030 Sustainable Development Goal 3 (“Ensure healthy lives and promote wellbeing for all at all ages”) sets out universal health coverage as a target. As yet that goal is not always realised in practice especially in the less formalised segments of societies and economies; segments which have grown hugely with demographic changes, including urbanisation.<sup>7</sup>

One significant result has been a reproduction in the health sector of the “poor pay more syndrome” identified in consumer policy research during the 1960s and 1970s in retail markets of high income countries and to which attention was drawn by the United Nations Conference on Trade and Development (UNCTAD) in its 2017 Consumer Protection Manual.<sup>8</sup> This is reflected today in low-income countries by the high levels of “out of pocket” payments by low-income consumers outside social protection systems and thus with lower levels of access.<sup>9</sup> This syndrome has been thrown into sharp relief by the COVID-19 pandemic.

## SECTION 1: SOCIAL PROTECTION IN A CHANGING WORLD

### 1.1 Compatibility of Social Protection with Informal sectors

The concept of social protection is part of a wider public policy realm which can be subdivided into various systems related to social insurance, social

assistance, basic health services and information systems. In the context of the present and potential future pandemics, social protection mechanisms constitute a major part of the response, not only as part of the health services or health ministries but also as part of the wider armoury of public intervention. Social protection systems, first established in high-income countries, have served well and in today’s crisis have the merit of being based on an existing infrastructure. However, there is cause for concern when considering their long-term viability, especially in developing countries.

Recent estimates from the International Labour Office (ILO) are that two billion people, (61 per cent of the globally employed population) earn their living in the informal economy which accounts for 90 per cent of total employment in low income countries (LICs) and two thirds in the middle income countries (MICs), in contrast to 18 per cent in high income countries (HICs).<sup>10</sup> During the first month of the COVID-19 crisis in Africa and Latin America, informal workers are estimated to have lost nearly 80 per cent of their earnings.<sup>11</sup> Such alarming statistics confirm the concerns expressed by the ILO in 2015 and addressed by ILO Resolution 204 on “Transition from the Informal to the Formal Economy,” which called on member States to adopt a policy framework addressing “access to financial services... access to infrastructure and technology... establishment of social protection floors and the extension of social security coverage.”<sup>12</sup>

The global network of Women in Informal Employment, Globalizing and Organizing (WIEGO) highlights in a recent survey how: “for workers who depend on their daily earnings to survive—whether they are self-employed, wage workers, casual day labourers or dependent contractors—not working is no option. Thus, they must decide between staying home and falling into extreme poverty or risking infection to earn their livelihood.”<sup>13</sup>

WIEGO’s conclusions included that health guidelines for COVID-19 as developed by international organizations are not well suited to low-income contexts, citing the difficulty of social distancing or the necessity for isolating in addition to the lack of access to running water in informal settlements. They found that: “where health and hygiene guidelines had been developed for workplaces, these focused almost entirely on formal workplaces.” This demonstrates the need for measures to fit local circumstances. An analysis for ILO states that many governments have

failed to move in this direction, even to the point of making things worse: “Generally, the existing legal and regulatory frameworks tend to be irrelevant or punitive towards the informally employed and their livelihood activities.”<sup>14</sup>

## 1.2 The informal economy as service provider

The concern with the informal economy does not stop at worries about what will happen to those workers whose jobs vanish during lock downs, sometimes temporarily. Many informal workers carry out important services in places not reached by formalised services, such as provision of drinking water, fuel, and sanitation, often provided on an unregulated basis by vendors or improvised networks, some of which may be illegal, but which often go ignored by the authorities.<sup>15</sup>

An OECD publication observes: “If there is one thing that COVID-19 has highlighted, it is that informal workers are not residual to our economies. Many are essential workers who today are responsible for ensuring food security, collecting our waste and recyclables, and providing care work. Despite the tremendous value of this work in sustaining our economies and societies, informal workers are too often excluded or marginalized within economic and social policy. Going forward, this needs to change.”<sup>16</sup>

This may be happening as has been noted acerbically by WIEGO (cited above) under the heading “from evicted to ‘essential’ overnight”, a reference to what they describe as: “harassment by authorities, vilification in the media” - a pattern which they hope may be diminishing following a shift towards growing recognition among policymakers and the public alike.<sup>17</sup>

The questions around the design of social protection systems can lead to debates about eligibility and conditionality. The overriding urgency of the current circumstances require systems that are simple to understand and administer, and comprehensive in scope. This can involve difficult trade-offs and identifying the “right” answer is far from easy. Hasty solutions established for the best of reasons can have perverse consequences. For example, some forms of social assistance in developing countries have, for many years relied on universal subsidies (notably for water and energy). These had the advantage of being simple to understand and administer, but they have had the long-recognised disadvantage of being very inequitable, subsidising the wealthy while not serving the unconnected poor, who instead have to buy from unsubsidised and often informal suppliers. This “gap-

filling” by unrecognised providers is a classic example of the “poor pay more” syndrome.<sup>18</sup>

The informal sectors, so often seen as a problem, can actually make substantial contributions to the coverage of such important sectors as water and energy. Their continued absence of recognition and improvement intensifies the exclusion from public service of people living and working in informal settlements and workplaces.<sup>19</sup> But the process of integration is a long haul, while pandemics and other public health emergencies require rapid response.

## 1.3 Role of UNCTAD and how its consumer protection mandate links to social protection policy

In view of the major and persistent social gaps that the pandemic has widened, the Economic Commission for Latin America and the Caribbean (ECLAC) has reiterated that “it is time to implement universal, redistributive and solidarity-based policies with a rights-based approach, to ensure that no one is left behind.”<sup>20</sup> ECLAC links this with the International Labour Office (ILO) Social Protection Floors Recommendation, 2012 (No. 202) calling for, “high quality public services that enhance the delivery of social security systems.”

Health is recognised as a human right. Article 12(1) of the United Nations International Covenant on Economic, Social and Cultural Rights recognises: “The right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”<sup>21</sup> According to the United Nations Committee which monitors progress, it is “an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information...”<sup>22</sup>

This wide interpretation of health reflects the preamble to the World Health Organization (WHO) constitution, which states in its second principle: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”

UNCTAD is the focal point for consumer protection law and policy within the United Nations system as



conferred by the United Nations General Assembly resolution UNGA 70/186 of 22 December 2015, which approved the second and latest revision of the United Nations Guidelines for Consumer Protection (UNGCP).<sup>23</sup> The General Assembly “reaffirmed” the Guidelines “as a valuable set of principles for setting out the main characteristics of effective consumer protection legislation, enforcement institutions and redress systems and for assisting interested member States in formulating and enforcing domestic and regional laws, rules and regulations that are suitable to their own economic and social and environmental circumstances, as well as promoting international enforcement cooperation among member States and encouraging the sharing of experiences in consumer protection” circumstances, as well as promoting international enforcement cooperation among member States and encouraging the sharing of experiences in consumer protection.

UNCTAD promotes the Guidelines and encourages interested member States to create awareness of the many ways in which member States, businesses and civil society can promote consumer protection in the provision of public and private goods and services.<sup>24</sup>

UNCTAD has a long-established relationship with consumer protection agencies working as market supervisors.<sup>25</sup> That role features heavily in UNCTAD’s published work including:

- The United Nations Guidelines for Consumer Protection (UNGCP) 2015.<sup>26</sup> Several guidelines are relevant to health policy, as follows: Under the “legitimate needs” (Chapter III. General principles, guideline (GL) 5): (a) access by consumers to essential goods and services; (b) the protection of vulnerable and disadvantaged consumers; (c) the protection of consumers from hazards to their health and safety; e) access by consumers to adequate information to enable them to make informed choices according to individual wishes and needs; (f) consumer education; (g) availability of effective consumer dispute resolution and redress; (k) the protection of consumer privacy and the global free flow of information,
- The new Chapter IV of the UNGCP Principles for good business practices (GL 11, including fair and equitable treatment, commercial behaviour, education and awareness-raising and protection of privacy, consumer complaints and disputes). For the first time,

the UNGCP directly addressed service providers in 2015, encouraging consumer protection compliance,

- Within Chapter V, sections on Physical Safety (B, GLs 16-19), Standards for the safety and quality of consumer goods and services (D, GLs 33-35), Dispute Resolution and redress (F, GLs 37-41), Education and information programmes (G, GLs 42-48, referring specifically to “health, nutrition, prevention of food-borne diseases and food adulteration,” GL 44 (a), and
- Section K on Measures relating to specific areas, recognizing health and pharmaceuticals as “areas of essential concern,” GLs 69 and 74-75.

The UNCTAD Manual on Consumer Protection, 2017, covers many health-related sectors such as food and utility services and cross-cutting topics such as privacy, data protection and dispute resolution.<sup>27</sup> In addition, many detailed briefings can be found on generic consumer issues in papers prepared for the UNCTAD International Group of Experts (IGE) on Consumer Protection Law and Policy.<sup>28</sup> The focus on health was already increasing in UNCTAD’s consumer protection work before the COVID-19 crisis, in particular: “Achieving the Sustainable Development Goals through Consumer Protection,” UNCTAD, 2017.<sup>29</sup> This includes both health and health-related SDGs such as SDG 6 regarding water and sanitation and SDG 7 on energy.<sup>30</sup> It draws the links between consumer protection and those SDGs most relevant to the wider Social Protection project such as SDG 1: (“End poverty in all its forms everywhere.”); SDG 3: (“Global Health and Wellbeing.”); SDG 5: (“Gender Equality and Empowerment of All Women and Girls.”); SDG 8: (“Decent Work and Economic Growth.”); SDG 10: (“Reduced inequalities.”); SDG 12: (“Sustainable Consumption and Production.”); and SDG 17: (Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development.”).

The 2015 United Nations General Assembly resolution 70/186 on consumer protection introducing the revised UNGCP, clearly states the link between consumer protection and the SDGs. SDG 3 reads: “Ensure healthy lives and promote wellbeing for all at all ages,” and is linked to target 3.8: “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services

and access to safe, effective, quality and affordable essential medicines and vaccines for all.”<sup>31</sup>

Other UNCTAD activities have also evolved to cover areas of relevance to health and consumer protection. For example, the UNCTAD programme on evaluating E-commerce readiness is working on reinforcing consumer protection against online scams (which may include, for example, fraudulent health products) and advising on matters of data protection, identity, and privacy.<sup>32</sup> UNCTAD first introduced the B2C E-commerce Index in 2015 as well as the cyber law tracker.<sup>33</sup>

#### **1.4 Social protection, consumer protection, quality of, and access to, basic health services**

Consumer protection has tended to focus on consumers’ transactional rights, whether through contracts or statutes – one might call this approach “shoppers rights.” The concept of consumer policy has recently widened, so that agencies other than those primarily entrusted with a consumer protection mandate are increasingly asked to take into account the consumer/user dimension. This has led to greater emphasis in consumer policy on the crucial matter of access and thus, to the plight of “non-consumers” who do not have access to essential services such as water, sanitation, energy, and indeed health. As evidence of this shift, in 2015, a new sub-paragraph was inserted into UNGCP Guideline 5 which lists the “legitimate needs” of consumers. The new text includes, “access by consumers to essential goods and services” and “the protection of vulnerable and disadvantaged consumers.”<sup>34</sup> Furthermore, this follows the Objectives set out in Guideline 1 which includes the right of consumers, “to promote just, equitable and sustainable economic and social development and environmental protection.”

Access to essential services is, therefore, a relatively recent addition to the consumer protection lexicon. Prior to 2015, when health was dealt with in consumer protection discussions, it tended to be in terms of avoidance of harm from hazardous products or, certain commodities such as food, water and pharmaceuticals sold in the market. In this regard, UNGCP Guideline 69 calls upon member States engaged in “advancing consumer interests, particularly in developing countries,” to “give priority to areas of essential concern for the health of the consumer.”<sup>35</sup> This protective stance emphasizes compensation for harm of existing users

rather than addressing the needs of non-consumers, that is, those not receiving service.

By focussing attention on the unserved consumers, COVID-19 may have dented the syndrome of a wide range of service deprivation (not just in health) throughout developing countries. The pandemic has brought into sharp relief the link with broader social support, because of the need to provide financial help at short notice. This raises questions about the use of electronic identifiers to confirm eligibility for help and to keep track of payments made, including those for health treatment.

This broader range of support must be provided with due diligence regarding protection of consumer privacy, also listed as a “legitimate need” in the UNGCP (see above). In addition to vital matters of access and privacy, consumer tools for representation, redress, and machinery for collective guarantees of users’ rights, could contribute to considerations of quality in health services through mechanisms of consumer feedback.

Health services comprising, as they do, of strong elements of generic public health, have a collective dimension which does not lend itself to “contractualisation” between individual parties. Guideline 1 of the UNGCP draws attention to imbalances in consumer-professional relationships and there are such intrinsic imbalances inherent in patient – professional relations. <sup>36</sup> In the case of health services, the idea of equal protagonists has rarely been assumed in the first place and the patient generally defers to the professional judgement of the medical practitioner who, in turn, has strong ethical obligations towards the patient, reinforced by a high degree of self-regulation. To address the imbalances that exist between consumers and professionals, the UNCTAD publication in 2017 on the role of consumer protection in achieving the SDGs stated that, “State intervention (is necessary for) ensuring that suppliers behave responsibly and that aggrieved consumers have access to remedies.”<sup>37</sup>

The institutional arrangements for such intervention are complicated by the sheer size and diversity of the health sector. Quality is difficult to define and to separate from access and affordability. In their wide-ranging study of access to health care in developing countries, Peters et. al. in 2008 pointed to the quality of care as being at the centre of geographic, financial and cultural accessibility and reported instances in which “patients’” perceptions of quality can be more

important determinants of utilization than prices or other dimensions of access.”<sup>38</sup> They went on to indicate that even successful interventions in varying locations do not suggest a “magic bullet,” but they do conclude that, “the challenge remains to find ways to ensure that vulnerable populations have a say in how strategies are developed, implemented, and accounted for.” This suggests that there is, at least, a need to develop mechanisms for listening to users of health services and that responsiveness forms a part of quality assessment.

Consumer grievances in health services: Grievance procedures for consumers occupy a wide spectrum from simple complaints procedures to court-based compensation actions. Many doubts have been expressed about the appropriateness of judicial remedies, a shift described in an UNCTAD briefing as “scepticism, involving the desire to move away from judicial redress towards out-of-court dispute resolution mechanisms.”<sup>39</sup>

Internal complaint handling systems: The 2017 UNCTAD Consumer Protection Manual points out: “many cases that go to Ombudsmen (see below) would be more simply resolved by better internal management of enquiries.”<sup>40</sup> Indeed, simple enquiries can unintentionally be turned into disputes by being treated as “complaints.” A further problem for policymakers is that complaints systems will naturally reflect the needs of those who have access to the services rather than those who cannot gain access, perhaps the most serious failing of all. The 2016 UNCTAD study of consumer protection in health care in Southeast Asia made the following point which is highly relevant to COVID-19: “There is inadequate data on consumer complaints relating to health care services. Where evidence does exist, it is limited to complaints by those already accessing mainstream hospitals or professional regulatory systems.”<sup>41</sup> Furthermore, a common problem with complaints data is that it depends on there being avenues for complaints to be made. This can produce the paradox that new or improved complaints mechanisms will produce a higher level of complaints. That is a necessary phase.

Public redress bodies: There has been a gradual acceptance that complaints and dispute mechanisms should be directed at the service rather than at individuals. While Ombudsmen schemes can make recommendations on compensation, such cases are not necessarily restricted to financial redress. The remedies can be as simple as the delivery of a

promised service to a given community, for example, thus addressing the problem of non-service.

UNCTAD has listed quality criteria against which consumer dispute resolution and redress may be evaluated and Ombudsmen feature as viable bodies.<sup>42</sup> The development of the Ombudsman concept originated in Sweden in response to the consideration that States had a conflict of interest when adjudicating on their own services. More recently, the Ombudsman concept has extended to the private sector, but a distinct feature of public service Ombudsmen is that they can resolve both individual and collective cases because of their ability to aggregate case files (with strict protection of anonymity). This makes the Ombudsman concept particularly appropriate to health services in the context of systemic improvements.

The limitation of the public Ombudsman to publicly provided services could involve problems of definition, because the distinction between public and private can be unclear. Public services often receive payment from patients at the point of use, while private practitioners are sometimes free of charge. Informal payments are widespread by custom and practice, as identified by WHO analysis, (see section 1.4).<sup>43</sup> One truly comprehensive way to bring all health systems within the ambit of an Ombudsman system (or whatever equivalent) is to make inclusion in such redress systems a condition of entry into the profession. That could have the advantage of addressing two problems at once, that of informal payments and that of lack of redress mechanisms.

Compensation for medical accidents: One particular difficulty in applying consumer protection to health services arises from the notion of redress or compensation for service failures including medical accidents. This compounds, and is compounded by, the psycho-social barriers to redress in health, which are rendered all the more complex in the context of clinicians and other practitioners operating under pressure, as in pandemics, and faced with logistical difficulties, such as in emergencies. In such circumstances, the risk of accidents is increased. Even without such extreme circumstances, the benefit of pinning blame on one party is questionable. On the other hand, consumers need to be compensated if they suffer adverse consequences, even from a service which on balance has brought benefits to most of its users.

The discussion is complex and legalistic. In summary, one can envisage the obligation to compensate in the

event of service failure being replaced gradually by the right of the patient to receive reparation for damage done during a course of treatment. Fundamentally, the question arises as to whether such a right goes beyond matters of liability and extends to a more general right for compensation for damage suffered regardless of the cause. Accepting that principle would make social protection more equitable. However, a recent report by the British Department of Health Reviews Facility reviewed a variety of schemes and concluded that it would require, “the existence of a comprehensive national social welfare/social insurance system.”<sup>44</sup> If this is a pre-requisite, then it makes the prospects for such a development in many low-income countries appear unlikely in the near future. Nevertheless, with a comprehensive system in place, then in due course, it would be coherent in administrative and social terms.

### 1.5 Financing the service and affordability

The State plays a prominent role in health services as in other essential services, in particular as guarantor of access and affordability. There are two major and overlapping demands by consumers/users on the financing of health services: 1) regarding the contributions of users to the service itself and 2) the need for substitutes for regular incomes for people no longer able to work due to illness. Globally, the financing of both health and social security measures is dominated by government resources, sometimes through quasi-autonomous social insurance funds operating in partnership with governments, based on “social registers”, through which individuals’ eligibilities are recorded.

Health service spending: WHO analysis of the 2017 global health spending reported huge differences between countries at different income levels. The average health spent per person (from all sources) in HICs came to US\$ 2,937 per annum, while that for LICs was more than 70 times lower at only US\$ 41.<sup>45</sup> HICs accounted for 81 per cent of global spending for only 16 per cent of the world’s population. The same document reported that public financing accounted for about 60 per cent of global health expenditure in 2017; an increase from 56 per cent in 2000.<sup>46</sup> One can observe a clear gradient of public sector involvement in health care spending —falling from 69 per cent in HICs, to 57 per cent in upper-middle income countries (UMICs), and to 44 per cent in lower-middle income countries (LMICs), before falling again to 24 per cent in LICs.<sup>47</sup> Conversely, the proportion of out-of-pocket

spending (OOPS) slopes in the opposite direction, albeit with a lesser gradient. OOPS accounting for 22 per cent in HICs, 31 per cent in UMICs, 40 per cent in the LMICs and 41 per cent in LICs.<sup>48</sup> This clearly raises serious issues around equitable access, reflecting as it must, serious disparities within some of the poorest countries, raising questions on how they can honour undertakings to provide health services as a human right.

The social health insurance model (SHI) developed in the OECD countries has seen only gradual increases in coverage in recent years. The number of countries with SHI has increased by 13 since 2000, reaching 126 in 2017. However, the share of SHI in current health spending in 2017 was only 1 per cent to 2 per cent in LICs, in contrast to 4.5 per cent to 8.5 per cent in LMICs and 16 per cent to 20 per cent in UMICs.<sup>49</sup> SHI based on contributions, often from payrolls, can be seen as a way of securing resources, with the contribution being seen as “hypothecated” (i.e., reserved) and bestowing entitlement on the user. However, this logic is diluted by the fact that about two-thirds of countries with SHI use government budget transfers as a funding source.<sup>50</sup>

The above analysis about the progress of SHI seems disappointing in terms of coverage. A detailed analysis by WHO in 2019 concluded that: “These divergent patterns suggest there is no magic in SHI that leads automatically to increases in revenue and spending. What matters is the political choice by countries to increase health spending. For low- and middle-income countries, the choice is about the level of budget funding, whether channelled through SHI or not.”<sup>51</sup> Indeed, WHO concludes in one heading that, “the original model of funding social health insurance is not consistent with universal health coverage and is dying out.”<sup>52</sup>

The analysis concludes that, “SHI is not a ‘source’ of health spending but a health financing arrangement for that spending to flow ... the entitlement to benefits derives from a contribution made by or on behalf of each covered person, with coverage mandatory for some or all of the population.”<sup>53</sup>

This may underestimate the potential advantages of the SHI concept, which, after all and despite its problems, is still increasing in scope. The contribution may diversify funding, providing an alternative to mainstream taxation, on the grounds that it is dedicated to a specific contributor and for specific



purposes, thus creating a sense of entitlement. This is very important in underpinning user confidence in approaching service providers.

Despite its wide application, there are limitations, even disadvantages, to the social insurance model. If administered as a payroll tax with employer contributions it is sometimes said to discourage employers from recruiting.<sup>54</sup> It can also be exclusionary where there is sudden demand from the “non-entitled” such as cross-border refugees or indeed workers from the informal sectors during a health crisis. Such populations need to be “enfranchised.”

The failure to carry out such “enfranchisement” is shown indirectly in the proportions of “out of pocket spending” (OOPS), indicated above, which in turn may disguise significant numbers who simply do not receive care at all, (or postpone receiving it until it is too late) because they cannot afford the OOPS. Although precise estimates are always difficult to reach when they relate to something that does not happen (in this case people not seeking health care), there are clues such as the experience of countries that remove fees. In Burkina Faso, when user fees for children health care were removed, attendance doubled.<sup>55</sup> The same 2014 report found that in 22 African countries, household OOPS makes up more than 40 per cent of total health expenditure and much of it is informal. Simply getting rid of OOPS is not a simple process when the levels are so high, but its continuation, far exceeding social health insurance in low-income countries, is a serious cause for concern.

Income replacement transfers: The payment of sick leave raises a further question regarding equity of financial treatment between large categories of recipients of cash transfers. That relates, for example, to those who are not sick but who are laid off in order to prevent sickness from spreading. In fairness, they should receive an equivalent transfer payment most analogous to unemployment benefits, as they are being asked to sacrifice their source of revenue. While “furlough” schemes have been introduced in many HICs through wage support to companies, in the informal sectors, the laid off workers are frequently their own employers, but outside the register.

A way needs to be found to link entitlement to service with simple physical presence in a jurisdiction, and in fairness, some governments have responded quickly to the present crisis in that regard. The “living report”

of the World Bank records that 53 countries waived social security contributions or subsidized them in response to the crisis.<sup>56</sup> Furthermore, by June 2020, 49 jurisdictions introduced paid sick leave among the 195 countries/territories planning or introducing social protection measures in response to COVID-19, coming to 1,024 measures in all in that very short period.

We are already witnessing the development of electronic and biometric ID systems to extend the social registers.<sup>57</sup> In order to make this work, these emerging (or evolving) systems will need to reconcile such mechanisms for consumer access to service with personal privacy. The core principles are set out in the UNCTAD Consumer Protection Manual of 2017 as follows: openness, collection limitation, purpose specification, use limitation, security, data quality, access and correction, and accountability. This need for electronic identifiers has been intensified by COVID-19 because of the need for rapid roll-out, regardless of eligibility conditions. Even before COVID-19 these were already difficult matters of public finance, for large scale transfers cannot be made on an ongoing basis without systems of control and accounting.

Health services regulator: The logical parallel to the concept of an Ombudsman who deals with individual cases, as discussed earlier, would be the establishment of an independent health services regulator who could receive reports from Ombudsmen aggregating cases, identifying broad trends, and taking steps or proposing measures to counter systemic shortcomings. Such an office would retain public functions that are currently exercised directly by Health Ministries while not threatening the clinical independence which is so carefully defended by health professionals. There are parallels with the offices of regulators which have developed extensively throughout the infrastructure network services such as water and energy, and which exercise price supervision and controls, with a view to protecting consumers while ensuring that the sector has sufficient revenue to meet its obligations. Such regulatory bodies often have consultative advisory bodies involving representatives of the consumer interest and other stakeholders. Indeed, some of the authors advocated partnership between the State and “a variety of stakeholder groups such as consumer associations” to act as interlocutors with “organised interest groups” such as self-regulating professions and commercial franchises.<sup>58</sup>

The OECD defines a regulator as: “an entity authorised by statute to use legal tools to achieve policy objectives, imposing obligations or burdens through functions such as licensing, permitting, accrediting, approvals, inspection and enforcement.”<sup>59</sup> To apply the full range of such mechanisms in the difficult situations of low-income countries could be over-ambitious and even burdensome. However, there could be a role for regulatory oversight of particular dimensions of quality, access, and affordability with a remit to develop solutions and put them to Ministries of Health. For example, there is clearly a need to address the regressive pattern of cost to patients which is so dramatically illustrated by OOPS in low-income countries. A regulator could be given the dynamic role of evaluating the scope for, and developing options towards, risk pooling to provide financial protection in the context of countries without an existing comprehensive system of SHI.

Furthermore, the network characteristics of large-scale public health systems lend themselves to the regulator function, which would include matters of coverage. The dominance of public funding in health services justifies such a remit but also requires the independence of such an appointee, as criticisms may be addressed at failures in government strategy or policy including resource allocation. The regulator could, therefore, report to National Assemblies as well as to Health Ministries and could even be appointed by the head of government rather than the Ministry. There are many potential models that could be considered.<sup>60</sup>

In brief, there are positive lessons to be taken from the offices of regulators (for systemic regulation) and of an Ombudsman (as an agent for the rights of individual users) in many sectors, which could be of value to health systems too.

Whether the remit of a regulator would be confined to economic matters such as charging or to wider quality controls would be a matter for governments to decide at the point of initial legislation. In the last analysis it should be borne in mind that access to health is a human right and that it underpins the regulatory process.

The need for a comprehensive framework of physical and social infrastructure is creating common ground between health and consumer protection policy and there are analogous debates in areas of consumer protection law and policy. In addition to vital matters of

access and privacy, consumer tools for representation and redress and machinery for collective guarantees of users’ rights, could contribute to considerations of quality in health services, through mechanisms of consumer feedback.

## 1.6 International cooperation in consumer protection

The need for monitoring of commercial malpractice regarding health products in the retail sector may well increase, for the balance of electronic transactions is shifting from “traditional” traders that sell part of their products online, to third party marketplaces, including social media. A recent survey by UNCTAD in 23 countries in Africa, Asia, and Pacific regions, (predominantly least developed countries) found that during the course of the pandemic, 64 per cent of third-party marketplaces increased sales compared with 34 per cent of “traditional” e-commerce companies. Conversely only 29 per cent of third-party marketplaces saw declining sales compared with 58 per cent for companies selling by e-commerce. The report found that, “In a nutshell, wholly digital business models have been more resilient.”<sup>61</sup>

Some 12 per cent of sales by companies linked to e-commerce were for “pharmaceutical health and hygiene” products and for third party sales the proportion climbed from 10 per cent to 17 per cent of sales during the pandemic. The full implications of this for health are not yet clear, but these are significant trends, especially if corporate entities are not based in national territories. The problem of extra-territoriality has featured in regional surveys such as the evidence gathered for the West African Economic and Monetary Union discussed in Section 3.2 and this remains an issue for many consumer protection authorities.

The United Nations Guidelines on Consumer Protection and international cooperation: The UNGCP contain recommendations for international cooperation between consumer protection agencies (GLs 79-94). The need for collaboration between member States in cross border cases is specifically mentioned in the new section on electronic commerce (GL 65), a particularly critical sector in terms of cross-border sales raising difficult problems of jurisdiction. The section of the UNGCP on International Cooperation, (Section VI), was significantly expanded as a result of the 2015 revision process.

- GL 79b) calls for cooperation for “joint use of testing facilities, common testing procedures, ... and joint elaboration of regulations,”
- GL 79c) makes a highly COVID-19 relevant recommendation: “Cooperate to improve the conditions under which essential goods are offered to consumers, giving due regard to both price and quality. Such cooperation could include joint procurement of essential goods, exchange of information on different procurement possibilities and agreements on regional product specification,”
- GL 80) calls for strengthened information links regarding banned, withdrawn or restricted products, a vital matter for consumer safety,
- GL 82) calls for cooperation on cross-border fraud, while entering a caveat (see below) regarding the freedom of decision of national jurisdictions. This leads to:
  - GL 83) national consumer protection agencies need to “avoid interference” in the work of agencies in other jurisdictions. So, GL 84 recommends resolving disagreements around cooperation and GL 85 envisages bilateral or multilateral arrangements, and
  - GLs 86/87 envisage a “leading role” for mutually designated agencies on particular enforcement issues and GL 88 states that exercise of national authority to investigate and share information should extend to foreign counterparts.

Much of the information in the text above depends on the goodwill of consumer protection agencies. When it comes to legal enforcement across borders, there are perennial problems which the Guidelines have not been able to resolve. These revolve around the issue of establishing the “applicable law and jurisdiction.”<sup>62</sup> GL 82 recognizes that “cooperation on particular investigations or cases...remains within the discretion of the consumer protection enforcement agency that is asked to cooperate.” In other words, an agency cannot be forced to act by a sister agency in another jurisdiction.

#### Potential improvements in international cooperation:

As suggested by GL 88, considerable progress can be made by voluntary sharing and warning. The OECD reported in 2018 that, “Countries are generally active in some form of cross-border co-operation. A majority reported that their enforcement authorities will notify foreign authorities if they receive information on businesses located in their country that cause economic damage to consumers.”<sup>63</sup>

Indeed, an OECD survey reported that, “All but two countries... have put in place arrangements or legal frameworks with foreign authorities for... co-operation.... including information sharing, as well as collaboration on guidance for businesses, investigations, and enforcement actions... a number of OECD countries have enacted legislation that specifically provides for information sharing and investigative assistance.”

Examples of cross-border cooperation can include those between consumer protection agencies at the level of dubious retail health products. For example, in March 2020, the Italian consumer protection authority launched an investigation with a view to ordering, if necessary, an interim measure against a United States company and its Dutch subsidiary, regarding the sale on its platform of products claiming to prevent contagion from COVID-19.<sup>64</sup> Sometimes, cooperation consists of simple information exchanges for chasing fraudsters, or discussing price manipulation by multinational companies. For example, it has recently been alleged that multinational companies have manipulated the delivery of face masks to raise prices.<sup>65</sup> Nevertheless, it remains relatively rare for a consumer authority to use its statutory authority (eg. a court order) to obtain information from a domestic business in aid of a foreign investigation.

The OECD report indicates that there is still some way to go, “Despite improvements in frameworks for cross-border enforcement co-operation, only half of the authorities have taken joint or co-ordinated enforcement actions with their foreign counterparts.”<sup>66</sup> The resolution of difficulties around applicable law and jurisdiction remains problematic.

### 1.6a Case study: International Consumer Protection and Enforcement Network (ICPEN)

Consumer protection agencies are becoming increasingly adept at cooperating across borders without resort to court proceedings, for example, by persuading colleagues in other jurisdictions to act. Cross border exchanges have been set up by ICPEN, composed of organizations in over 50 countries, aiming to:

- Protect consumers' economic interests around the world,
- Share information about cross-border commercial activities that may affect consumer welfare,
- Encourage global cooperation among law enforcement agencies.

While the initial membership of ICPEN was predominantly from OECD countries, it has spread further afield to all continents. Regional bodies can join as observers, as has UNCTAD.

ICPEN runs the annual Fraud Prevention Month and carries out the annual Internet Sweep which searches for websites that may be defrauding consumers. It enables cross-border e-commerce complaints "through means other than formal legal action" and distributes incoming complaints to national agencies. It has organised sweeps during 2020 concerned with COVID-19 – linked frauds.

*Source: ICPEN website*

According to a recent publication by UNCTAD on international cooperation in consumer protection,<sup>67</sup> substantive issues such as e-commerce, product safety and sustainable consumption, raised by cross-border trade are high on the agenda. International cooperation in consumer protection is growing within regional trade agreements as a means to facilitate trade and build trust in markets, while global policy and enforcement concerns are increasingly considered in multilateral discussions. These trends have been intensified by the COVID-19 induced economic crisis.

Nevertheless, international cooperation in consumer protection is only feasible when effective national laws, policies and institutions are in place. Technical cooperation with developing countries must remain a priority for all actors with stakes in consumer protection.

## SECTION 2: EHEALTH

### 2.1 eHealth as a promoter of access

The World Health Assembly's resolution WHA 58.28 of 2005 stated that, "eHealth is the cost-effective and secure use of Information and Communication Technology in support of health and health-related fields, including health-care services, health surveillance, health literature, and health education, knowledge and research."<sup>68</sup>

The resolution urges member States, "to consider drawing up a long-term strategic plan... including

health administration, which would include an appropriate legal framework and infrastructure." Such infrastructure should be developed, "as deemed appropriate to promote equitable, affordable, and universal access to their benefits," and furthermore, "to endeavour to reach communities, including vulnerable groups, with eHealth services appropriate to their needs."

According to a 2015 survey by the WHO Global Observatory for eHealth (GOe), more than half of the 125 responding WHO member States already had an eHealth strategy, 90 per cent of eHealth strategies referenced the objectives of universal health care and 83 per cent of countries reported at least one mHealth initiative (mobile).<sup>69</sup> eHealth had become mainstream by the middle years of the last decade.

Great enthusiasm for eHealth is shown by the World Bank whose concept note in preparation for the 2021 World Development Report, which focuses on "Data for better lives," discusses innovations in eHealth. It reports that: "Data can expand access, reduce costs, improve quality... data can help promote equitable and affordable access to health services."<sup>70</sup> The report specifies, for example, how the use of mobile phone data and mapping geospatial technology, greatly improved vaccination

attendance in Pakistan, therefore, boosting geographical coverage and vaccination rates.<sup>71</sup>

The use of eHealth during COVID-19 has rapidly increased during the current pandemic. It was stated



for example, at a recent OECD seminar on health care, that telemedicine, having only expanded by one per cent during 2018-19, had increased by one third during COVID-19.<sup>72</sup> eHealth is becoming normalised in those countries that have the infrastructure to support it; an important qualifier. Rather more challenging in policy terms as well as practical application is the linked issue of identity as an enabler of access. Access and delivery of basic health care services via digital means pose a number of challenges and questions which call on consumer and related policies through the key fields of data, privacy, intellectual property and competition. Intellectual property and competition also feature in the prospects for cooperation in research and development discussed in section 3.1.

“eHealth” may be too wide a term, encompassing technologies that have been in use for some time now. “mHealth” or “telehealth” might more accurately describe the most recent changes. In the GOe 2015 survey, mHealth was defined as the use of mobile devices – such as mobile phones, patient monitoring devices, personal digital assistants (PDAs) and wireless devices for both medical and public health practices.<sup>73</sup>

eHealth and the staff-patient interface: According to the United Nations Secretary-General’s report to the Economic and Social Council (ECOSOC) in 2019, “Available data from 2013 to 2018 indicate that close to 40 per cent of all countries had fewer than 10 medical doctors per 10,000 people, and more than 55 per cent had fewer than 40 nursing and midwifery personnel per 10,000 people.” The same applied to virtually all the least developed countries,<sup>74</sup> and concerns have been expressed about the ageing health workforce and “replacement challenges.”<sup>75</sup> Given these constraints, the actual and potential gains from eHealth are undoubtedly there but there are dangers of exaggerated expectations.

Some of the benefits simply reflect the technological evolution that takes place in many services. For example, as reported by GOe, (cited above) electronic immunisation registries have been used in Latin America for a long time; since the late 1980s in Uruguay. The vaccination data still have to be collected on paper and data need to be entered close to the delivery time and place of the service. Similarly, the use of an mHealth app reported by GOe in Uttar Pradesh, India, replicated paper registers which the frontline workers were required to carry and had to be transposed.

Nearly half of all countries now use remote patient monitoring and the same proportion, 47 per cent, use national electronic health record (EHR) systems. The GOe describes implementation of EHR programmes as complex and costly, but points to “the potential to provide clinical decision-makers with complete and accessible information for every patient at point of care, thereby improving the quality and timeliness of care and in aggregate, providing better data on effectiveness and coverage of interventions.”

Although in theory the obstacle of distance is reduced, this is based on a major condition, namely that the transmission be not interrupted. Practical issues intervene, such as that of theft of phones or tablets, or clinics only having electricity for limited hours per day and having to pay for data storage and transmission. Technical limitations are suggested by comparison with relatively simple e-commerce transactions in the least developed countries where only 1 in 5 use the internet and less than 5 per cent use it to buy goods and services online. The UNCTAD eTrade Readiness programme shows that, “The quality and affordability of broadband connectivity – especially in rural areas – typically must be greatly advanced... There is a need to strengthen the protection of users and consumers to boost trust in online commerce. Efforts to strengthen cyber security are equally important.”<sup>76</sup>

The Global Health Workers Network, (GHW Alliance until 2016) convened a high-level commission on health employment and economic growth, whose expert group reported in 2016.<sup>77</sup> The report considered the role of eHealth and concluded, “There are many obstacles to overcome before fully realizing the potential of technology to fill the health workforce gap, including lack of Internet access and ICT infrastructure for two thirds of the world’s population, costs of connectivity, lack of electricity supply, insufficient numbers of experts in health information technology, lack of computer literacy among health workers, resistance to change among existing educators and health system managers, and an absence of evidence that investments in technology deliver cost savings and productivity gains, let alone improved health outcomes... The effects of digital technologies on the health workforce, although potentially positive, remains unclear.”

Nevertheless, the recommendation of the panel about Technological Transformation was that, “All countries must initiate programmes to enable health workers to use appropriate technologies, not only for optimally

delivering a wide range of health services, but also for efficiently and sustainably operating programme and policy relevant health information systems.” This balanced analysis seems to be borne out by experience such as the more recent analysis of past outbreaks by a team of tele-medicine experts from Iran and Australia. Their report strongly supports the use of telemedicine as a “routine” part of health care services but warns that, “Many developing countries are not ready to take advantage of telehealth, especially for their remote and rural areas despite the significant growth of technology, such as increased penetration of smartphones and the expansion of 3G and 4G internet networks.” They also warn about the lack of legislation or other rules to support telemedicine in many developing countries.<sup>78</sup>

## 2.2 Privacy and confidentiality

Health services have a long-standing culture of confidentiality, and this is unlikely to shift and for very good reasons. Privacy and data protection are of central importance both to consumer protection in general and to health services in particular.<sup>79</sup> Patients’ reasons for seeking privacy are frequently practical. Parents may wish to conceal an unconfirmed worry about a possible condition from their children or partners. When in need of advice or treatment, they may worry about the stigma of disease, especially during pandemics, as reported recently by the WHO African regional office.<sup>80</sup> Failure to safeguard privacy may result in potential patients staying away.

Given the increasing emphasis on eHealth, respect for confidentiality features even more among good business practices for promoting access. The 2015 revision of the United Nations Guidelines for Consumer Protection saw a new legitimate need introduced into Guideline 5, (k) The protection of consumer privacy and the global free flow of information.

The development of eHealth throws these factors into sharp relief as hacking could risk “mass break-ins” to electronic registers, such as those reported in an ILO study in 2018 concerning electronic and biometric identifiers.<sup>81</sup> The author is severely critical of what is seen as an excessively relaxed attitude towards privacy in the field of social protection for the less well off. “Social protection policymakers and practitioners currently tend to pay little or no attention to privacy and data security in relation to their programmes.” Significantly, the author finds that this is not a matter of lack of legislative provisions,

“In most countries, there are legal frameworks that govern privacy and personal data protection...(but)... Social protection programmes are often implemented without mechanisms that protect either the rights of the individuals whose information is being collected or the data itself.

She reports the rapid spread of such mechanisms in developing countries, often at the behest of donors of whom she is implicitly critical, “While many donors push for the introduction of biometric technology, there is little debate on the impacts of this technology’s use in social protection programmes; nor has there been any systematic or comprehensive mapping of programmes that use this technology.”

The summary concludes that, “While collecting and sharing personal information can increase

efficiency in social protection programme management and monitoring, (an important caveat) they can also threaten the rights, freedoms and personal security of those whose data is processed (applicants and beneficiaries) and indeed, of society at large.”

A risk that comes to mind is that the use of electronic and/or biometric signifiers (see case study below) will become a de facto condition of service. A United Nations report on poverty in the United Kingdom, a country with high levels of internet use, gives cause for concern with regard to digital requirements.<sup>82</sup> The digital application process for newly integrated social security benefits in the form of a new “Universal Credit” was described as, “putting some of the most vulnerable first in line for what amounts to a nationwide digital experiment.” A Government survey found that only 54 per cent of all claimants were able to apply online independently, without assistance. The rapporteur concluded that: “Despite official protests to the contrary, ‘digital by default’ is really much closer to ‘digital only’.”

Although the United Kingdom is a high-income country, this resonates with the ILO report cited above because of the common link to low income. The ILO report concludes, “Social protection programme beneficiaries do not renounce their rights to privacy and data security when they provide their personal information.” The rights of citizens to service, dependant on the use of electronic communication, could extend the “digital divide” to become an intensified social exclusion. For the principle of universal access to apply, then that of non-discrimination between modes of access also needs to be honoured.

Under the social protection measures discussed above, simple identity may be the key to eligibility. Sound digital ID systems can help with access to health services in the same way that they can for financial services, including state social security payments.

The same is true of non-digital ID systems too, with the difference being that digital ID can make use of unique and non-counterfeit “credentials” such as biometrics, as opposed to needing physical copies of birth and marriage certificates, proof of address, etc. Once issued, a digital ID can easily be kept safe or be carried around as an app on a smart phone. In the meantime, it should be noted that many people do not have smart phones and transition will take time and might not be smooth.<sup>83</sup>

There is a further risk of “mission creep” as acknowledged by the United Nations in the July 2020 report on COVID-19 in Southeast Asia.<sup>84</sup> Commenting on recently enacted confinement measures, the

report said, “Vaguely worded provisions without necessary safeguards and limitations have the potential to restrict the rights to information, privacy, and freedom of movement, expression, association, peaceful assembly and asylum. In some cases, there are no safeguards such as sunset or review clauses, in order to ensure return to ordinary laws as soon as the emergency situation is over, and it will therefore be important to review their application in line with international human rights law.”

A recent UNCTAD study points out, the expanded collection of data... can allow for mass surveillance. ... Some governments may face a trade-off between strict data protection regulations and the need to meet certain public health objectives.<sup>85</sup> One of the dangers this entails is that users of services may be discouraged from registering for services, unless forced or desperate. Box 2.2a presents the case of refugees and digital identities.

### 2.2a The case of refugees and digital identities

Digital identities can be understood as a set of electronically captured and stored attributes and credentials that can uniquely identify a person. A digital identity can be linked to an individual’s biometric details (such as photograph, fingerprints, or iris scan) for the purposes of targeted distribution of cash or of in-kind humanitarian aid.<sup>86</sup>

There have been various initiatives to enable refugees to have a digital ID to facilitate access to social protection services, for which a central problem revolves around the issue of proving identity. Failure of proof can result in driving a person out of the formal economy, thus running counter to a strategy of inclusion. There is also a vicious circle in which refugees need their mobile phones to store personal information related to their identity and yet slow issuance of identity documentation is hampering refugees’ ability to register for mobile services.<sup>87</sup>

Of the \$28 billion (US) per year distributed in humanitarian assistance, 94 per cent consists of in-kind transfers, while 6 per cent is cash. Of this 6 per cent, a certain proportion takes the form of electronic transfers. Digital ID can help ensure that the assistance in cash reaches the intended recipient. The authentication of a beneficiary’s identity is crucial to such cash transfers, because their advantages over in-kind assistance are only realized if disbursements can be made remotely and digitally, backed by appropriate ID and authentication systems. Traceability of funds is also a key government and donor requirement to scale up cash transfers given the high perceived risk of fund diversion or financing of terrorism.<sup>88</sup> Cash transfers may be more effective than in kind assistance in keeping the local economy going – that is of course a matter for local judgement, but without the development of ID mechanisms, that choice is pre-empted.

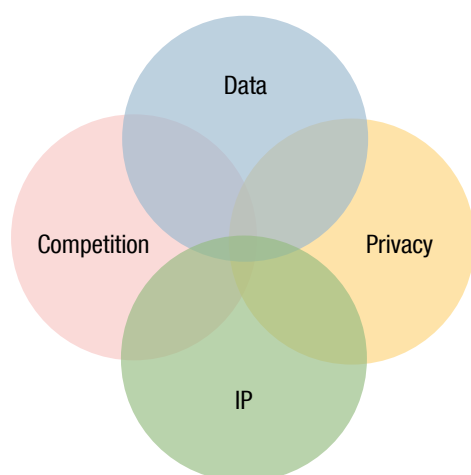
*Source: G20 Digital Identity Onboarding Report*

## SECTION 3: RESPONSES TO COVID-19

### 3.1 Intellectual property, research and development

The delivery and access of the vaccines to fight against COVID-19 pose great challenges for consumer protection. The actions in this regard have taken place outside of the remit of consumer protection agencies but are nevertheless vital to consumer welfare. The moves to promote research and development cooperation, much of which is likely to be cross-border, as well as open access to results, have been accompanied by modification of competition regulation, with the support of UNCTAD. This follows many years of advocacy by WHO, often encouraged by consumer associations. The diagram illustrates the inter-relation of the complex elements at stake.

Interaction between the 4 key elements



Source: UNCTAD

Among positive developments in global responses to the pandemic, the ACT Accelerator (Access to COVID-19 Tools) was launched in April 2020 to make COVID-19 testing and treatment available to all,

followed by the COVID-19 Technology Access Pool (C-TAP) in May. C-TAP was described as a “one-stop shop” and 37 countries undertook to support it on its first day. In his announcement of the C-TAP, the Director-General of WHO, Dr. Tedros Ghebreyesus, stressed that the initiative built on preceding work following the Doha agreement of 2001 on trade and public health and on the work of the Medicines Patent Pool which had contributed to combating HIV and Hepatitis B and which sub-licenses patents to generic manufacturers.<sup>89</sup> Further details of the negotiations are not entered into here. This episode serves to indicate how COVID-19 resulted in shifts towards greater flexibility as previously advocated by WHO and consumer advocates, among others.

### 3.2 Consumer protection enforcement during the pandemic

The declaration of pandemic by the WHO in early 2020 was the signal for intense activity around the world by Government consumer protection agencies creating a scenario for UNCTAD to amass considerable evidence of abuses reported to them.<sup>90</sup> In its report of April 2020, UNCTAD judged the coronavirus pandemic to have “opened the floodgates of unfair, misleading and abusive business practices, hitting consumers hard and leaving the most vulnerable ones more disadvantaged.” UNCTAD reported that, “price gouging for essential hygiene consumer products such as masks, hand sanitizer and basic household products have surged, forcing governments to insert price caps in various jurisdictions.” In the same report, the International Consumer Protection Network (ICPEN) identified areas of concern from 21 members in the COVID-19 context which included unjustifiable prices, misleading advertisements for ‘miracle products’ and financial frauds, including false appeals for donations or phishing. The box below presents some interventions by consumer protection agencies.

### 3.2a Case studies: Interventions by consumer protection agencies

On 27 March 2020, the Colombian *Superintendencia* of Industry and Commerce, in its role as the national authority for consumer protection, launched an investigation, while at the same time ordering the removal of any reference to the preventive and therapeutic effectiveness against COVID-19 of products advertised and marketed by three on-line platforms. This followed on explicitly from an announcement by the Ministry of Health and Social Protection to the effect that as of then, there were no products or medications capable of preventing the spread of the virus or curing those who suffer from it.<sup>91</sup>

This example is notable in two ways. Firstly, individual consumers were encouraged to report incidents of bad practice as the *Superintendencia* set up an app for that purpose. Secondly, it is a good example of interdepartmental collaboration leading to prompt action.

The European Union Consumer Protection Cooperation Network (between European Union Member-States) has circulated on-line platforms warning of scams and reinforced this action with electronic “swoops” to monitor compliance. The response of the platforms has often been very rapid removal of offending content, even though a significant number of irregularities may remain even after action is taken.<sup>92</sup>

As early as March 2020, some African governments intervened, despite the relatively low incidence of infection in the continent at that stage. For example, in Kenya, supermarkets were ordered by the competition authority to trace and refund consumers who had been charged excessively for hand sanitisers.<sup>93</sup> In Nigeria, a large e-commerce platform operating widely in West Africa, was obliged to delist from its platform 390 products belonging to 168 sellers of hand sanitisers and face masks, following a warning issued by the Federal Competition and Consumer Protection Commission, (FCCPC) to sellers engaged in price gouging and arbitrary increases in prices.<sup>94</sup> The delisting was carried out promptly.

Source: UNCTAD Newsletter and News Items and others on COVID-19 response by member States cited below.

By June 2020, over 30 countries in Sub-Saharan Africa had taken measures in response to COVID-19, of which, examples within the eight member States of the WAEMU included:<sup>95</sup>

- Quality standards for personal protection equipment, masks, and gels (8 States),<sup>96</sup>
- Price caps for gels (5), masks (3),
- Direct provision and subsidies (6 States), obligations to wear masks (5),
- Local production promotion (6 States),
- Tax exemption for pharmaceutical and medical goods (4 States),
- Price caps on basic goods and services (5 States),
- Free electricity and water (4 States),
- Support funds for large companies and small and medium enterprises (4 States),
- Support fund for the informal sector: only 1 State (Cote d’Ivoire), and
- Support fund for most vulnerable families, 2 States (Cote d’Ivoire and Mali)

Interventions have spread beyond market abuses to the consideration of the degree of dominance of certain traders in given markets.<sup>97</sup> COVID-19 saw a shift towards greater cooperation among competitors that might previously have raised concerns as anti-competitive agreements. In order to help guarantee supply of goods and services, such agreements were allowed in the European Union with safeguards, as well as in New Zealand, China and Canada.<sup>98</sup> Given the possibility for consumer protection agencies to act as close observers of the marketplace, it is possible that closer cooperation will be required to ensure that this more permissive attitude does not degenerate into abusive dominance.

On the basis of reports back from a wide range of consumer protection agencies in many countries, UNCTAD has issued the following set of nine key actions as recommendations to consumer protection agencies:<sup>99</sup>

- Set up coordination mechanisms composed of relevant government authorities, including health, customs, consumer protection and competition authorities,



- Set up special market monitoring initiatives on essential consumer goods, including those that help curb infection such as masks and hand sanitizers,
- Evaluate the viability of imposing price caps for certain products, such as masks and hand sanitizers,
- Undertake enforcement action against excessive price increases or hoarding of goods, misleading and false claims,
- Urge major online platforms to cooperate in identifying such practices,
- Attend to the needs of vulnerable and disadvantaged consumers, particularly to ensure their access to essential goods and services,
- Consider the possibility of extending deadlines for payment of monthly utility bills and credit cards in cooperation with financial institutions,
- Launch campaigns to inform consumers on scams and unfair business practices and on how to file complaints, showing the avenues for redress, and
- Cooperate with other consumer protection agencies by exchanging information on coronavirus-related national policies and measures.

The range of coordination envisaged illustrates the scale of the task, including points which indicate care to be taken for the most vulnerable. Specific programmes and actions need to be designed to help vulnerable groups, such awareness raising events targeting both urban and rural communities.

### 3.3 Force majeure

The UNCTAD list of measures was not just about enforcement. It also included measures to ensure availability of essential goods and services and the terms on which they can be obtained, including price. The implications are far-reaching, for this could involve large scale renegotiations of existing contracts or terms of service, such as those governing utilities and financial services. In such negotiations the consumer protection agencies could play an important role negotiating at scale as “honest brokers” or intermediaries in situations of “force majeure”; a term which has entered global legal terminology akin

to “Acts of God” in insurance. It allows contractual obligations to be amended during an extraordinary circumstance which prevents such obligations from being fulfilled. In some jurisdictions it is a contractual feature while in others it is a general legal concept subject to declaration by the courts that a particular event can be so considered.

This approach is draconian and yet was applied in many jurisdictions through the use of “emergency measures,” or “temporary arrangements.” For example, South Africa introduced restrictions on the enforcement of credit agreements, while several other jurisdictions including the United States and United Kingdom suspended evictions under certain tenancies due to non-payment of rents.<sup>100</sup>

More reflection is needed to illustrate how to balance consumer welfare with the rights of producers and suppliers, including maintaining incentives for businesses and consumers to prosper. As the COVID-19 Consumer Law Research group have pointed out, the COVID-19 crisis was “not the context for which consumer law, and general private law, was designed.” They identify, “a need to prevent as much as possible that courts are paralysed with several thousand additional COVID-19-related cases.” The group argue for extension of consumer credit agreements for example, beyond any moratorium, or a “compromise reduction in the agreed obligations of the parties.”<sup>101</sup> Because of the practical impossibility of renegotiation of millions of contracts, this obviously requires governmental intervention in the form of emergency legislation, or its prolongation where already in place.

## SECTION 4: RECOMMENDATIONS

The following issues have emerged during this study, some as a result of the COVID-19 emergency, while others reflect developments that were already under way in previous years, only for the emergency to accelerate the underlying trends. The analysis culminates in recommendations made to governments regarding the strengthening of consumer protection and welfare through the provision of health services, taking into consideration the needs of vulnerable consumers and the digital divide, heavily concentrated, as many are, in the informal sectors of economies. The recommendations below address legal and institutional frameworks, e-health, digital identity, and privacy issues, as well as international cooperation.

## 1. Consumer protection and human rights

Access to health services as a human right as referred in Section 1.2 clearly requires the commitment of Governments and national assemblies and enforceability by public bodies. This can be difficult if the competent supervisory institutions are not explicitly responsible for consumer protection in health-services and may thus be reluctant to act on behalf of service users. Increased cooperation between health authorities and consumer protection agencies is, therefore, extremely important.

There is a need to adopt and adapt some basic consumer principles which have been under-estimated in the health sector, in part because of the unique relationship between users and professionals in this domain. Attention is drawn, therefore, to the United Nations Guidelines for Consumer Protection and in particular to those “legitimate needs” associated with access to essential goods and services, protection of the vulnerable and disadvantaged, protection from hazards to health and safety, dispute resolution and redress, consumer representation and consumer privacy.

Secondly, concerning the place of consumer protection legislation within the wider bodies of law, many jurisdictions have civil codes running alongside sectoral legislation and this can cause legal confusion, especially where “horizontal” provisions, i.e., generic principles, are set down across the board while sectoral “vertical” legislation also applies. In the present context, consumer protection legislation can represent the horizontal axis while health legislation is the vertical with the further complication that much health-related policy is in the hands of ministries other than health.

The example is given of the Brazilian Consumer Defence Code whose horizontal consumer law principles apply to all economic sectors, counterbalancing the inequalities between the parties which are particularly acute in the health sector, by making clear that certain consumer rights are not overridden by contractual provisions.<sup>102</sup> This would, for example, allow unfair terms of service to be struck down and could also help develop a framework for underserved communities to assert their rights.

**Recommendation 1:** The right to health being recognized by the United Nations as a human right, member States should consider the United Nations Guidelines for Consumer Protection, in particular using the “legitimate needs” of consumers, as a checklist for the provision of health services.

The scope of consumer protection should be clarified as extending to all goods and services, (including those which are publicly provided) without excluding individual sectors. Sectoral legislation would apply but would not avoid consumer rights.

## 2. Comprehensive protection in the health context

The United Nations has consistently taken a broad view of health and health policy extending beyond the provision of services and medicines to matters of public and environmental health and social protection. The SDGs are testimony to that. The onset of the COVID-19 crisis has both validated and intensified that approach.

The crisis has been marked by massive state interventions to maintain incomes while shifting the focus of social protection beyond paying for health treatment and maintaining income during periods of sickness, to the broader issues of guaranteeing the incomes of the population as a whole. What remains unclear is the duration of such guarantees. The longer the emergencies last, the clearer it becomes that cash transfers need to be recurrent and regular rather than emergency one-offs. This requires a systemic approach to take over from the initial reactive position.

**Recommendation 2:** Comprehensive social protection health service mechanisms are needed in three distinct regards:

- The cost of medical treatment through the cycle of prevention, diagnosis, and prescription (all or any of which may be free of charge at the point of use),
- Income support for sick adults unable to work, as well as dependants, and
- Income support during pandemics for those unable to work because of confinement and other analogous measures.

Systemic development is required on a long-term basis for those social groups who currently lack coverage concerning the first two measures. The third measure applies to the current and future emergencies.

## 3. Financing of health services and affordability

The recommendation below responds to the significant finding by the WHO that “the original model of funding social health insurance is not consistent with universal health coverage and is dying out.”<sup>103</sup> This trend is

not only because of the exigencies of the current emergency. The judgement was made by WHO in 2019 in the light of reliance on direct government funding, which is heaviest in the richer countries.

This is so because the system of Social Health Insurance backed up by social assistance for the poorest, which underpinned many of the social security systems in the OECD countries, does not lend itself to the context and employment structure of large numbers of workers in low-income countries.

Direct payment for services: Low-income patients in low-income countries are paying a very high proportion of health spending from Out-of-Pocket Spending (OOPS) – 41 per cent compared with 22 per cent in high income countries – and some potential patients go without health treatment for want of resources to pay the charges.<sup>104</sup> Although significant improvements can be made through investment in scaled up public health interventions and infrastructure, there will always be cases where expensive interventions are necessary. This is a serious test of the human right to health, which, for reasons of lack of resources, will be difficult to pass. In the long run, social registers need to be built up to ensure access to service, but this takes time. The need for expanded social registers is addressed in Recommendation 9.

**Recommendation 3:** Systems are urgently needed to mitigate the high levels of Out-of-Pocket Spending which have a very regressive effect. The development of such systems could be mandated to sectoral regulators (see Rec 4). Large scale public health interventions with low unit costs should be carried out to strengthen resistance to disease and thus mitigate costs of treatment for both the service and for consumers paying directly. Investment in public infrastructure services such as clean water, sanitation and clean energy can provide a double benefit in improving public health while generating economic development.

#### 4. Health-services regulation

Legislation and regulation are used, "... to advance important policy objectives for their health systems, such as providing universal access to health services, establishing social protection floors, encouraging the efficient and equitable use of resources, or ensuring compliance with a country's international obligations," and "... to protect members of the public from harm ... in the health system (and to address market failure and inefficiencies...)," setting standards and requirements for services providers.<sup>105</sup>

A more dynamic concept than regulatory "command and control" may be needed, giving regulators the power to develop options and promote systems to overcome systemic shortcomings.

Representation and consultation of users: Consultative mechanisms involving consumers and professionals could be set up specifically for medical services.

Many governments are setting up generic consumer councils, either on a multi-partite basis (that is including the professionals) or simply representing the consumer interest before the relevant bodies. If councils are multi-sectorial, covering the entire spectrum of consumption, then the health sector could be "squeezed out" of a crowded agenda. Nevertheless, some cross-referral between a generic council and a health council could be useful. In addition to a consultative health council, consideration should be given to a sectoral regulator dealing with non-clinical matters such as user charges.

**Recommendation 4:** Governments should confer the close oversight and monitoring of health services delivery to expert and independent regulators entrusted with the mandate to protect consumers/users' rights including looking into possible improvements. These regulatory bodies should also be conferred a mediation role (as Ombudsmen) and be encouraged to adopt a high public profile being able to deal with individual and collective complaints including those involving independent practitioners working within the health service. The governance structure of these regulators should include the participation of consumers/users of health services representatives in advisory bodies and in any wide consultation mechanisms, providing opinions and suggestions towards the increased protection of consumers/users' rights.

#### 5. Consumer grievances

Dealing with medical accidents through judicial mechanisms is widely considered to be arbitrary, stressful, and expensive. Compensation should shift towards the fact of harm rather than the attribution of blame or fault, which can often be diffused, and which should in any case be considered separately. This is a complex area, which deserves more study, including the possibility of no-fault compensation and social security mechanisms as channels for compensation. Such mechanisms are unlikely to be a priority during the crises such as COVID-19 and should be considered over the longer term.



Different recommendations relate to different levels of grievance. Such procedures are unlikely to take place within a contractual framework. Indeed, only in extreme situations such as refusal of service is statute law likely to be invoked. Many complaints and enquiries relate to procedural and administrative matters and as such, can provide useful feedback.

Consumer associations: The various mechanisms to protect consumer rights can be legal and institutional and sometimes the supervisory institutions need to be encouraged to act. Consumer associations can be recognized as competent to act on behalf of consumers or they can carry out procedures, sometimes known as “super complaints,” requesting the courts to oblige public institutions to take action. In the health field, one could imagine such a safeguard being used in the event of particular communities or social groups not being served.

**Recommendation 5:** The treatment of medical accidents would benefit from less focus on liability of individual parties. Redress for injured consumers could be applied through more generic and administrative modes than the adversarial liability route, while systemic problems can be approached through less judicial procedures. Malpractice, where it occurs can be dealt with by internal systems, through administrative or professional mechanisms, without obliging users of the service to trigger such proceedings. Competent consumer associations or other competent representatives of health-services users should be enabled to take legal action to assert their rights as, or on behalf of, users or potential users of a service.

## 6. Consumer protection law enforcement and international cooperation

Consumer protection agencies have been prompted to intervene in cases of price manipulation of medical products and misleading claims such as miracle cures. The implications for health services and for consumer protection agencies of shifts in electronic transactions from traders that sell part of their products on-line, to third party marketplaces, including social media should be monitored. Increased resources and expertise need to be made available to consumer protection agencies to monitor electronic sales, especially if businesses do not have legal presence in the jurisdiction where their goods are sold.

International cooperation in consumer protection: Exchanges of information are needed by national consumer protection agencies in the event of

fraudulent or misleading practices carried out in other jurisdictions and which may spill over into a national jurisdiction through e-commerce including third party marketplaces. The problem will not go away as electronic commerce continues to grow. While information can be exchanged between authorities, efforts to carry out cross-border judicial action are frustrated by the failure of international bodies to arrive at a common position on “applicable law and jurisdiction.” That failure imposes limits on the cooperation that an agency can expect from a sister agency in another jurisdiction. COVID-19 has certainly led to further discussion on this matter and voluntary cooperation can be very helpful, but as yet, few definitive steps can be discerned.

Cooperation for research and development: The agreements that have been reached during COVID-19 regarding inter-firm cooperation on vaccine development are to be welcomed especially in the context of pandemics. There are conceivable long-term risks for consumers and health services that might result from reduction in competition. This calls for monitoring of the risk of “blended violations” in several fields (consumer protection, competition, intellectual property, data protection, privacy) and requires cooperation among the respective domestic regulatory bodies and at the international level.

**Recommendation 6A:** Consumer protection agencies need to maintain their vigilance in monitoring abusive business practices in the field of retail health-related products. They should also closely monitor the increasing sales of medical products online. Consultation with relevant international bodies should further enable cross-border investigations of abusive practices, should that prove necessary.

**Recommendation 6B:** In the light of the urgency of research cooperation to help develop vaccines and other health treatment products, the scope for encouraging open-source research should be explored by consumer protection and competition authorities, in collaboration with health authorities, bearing in mind the need for investment in research and development and the lack of such research capacity in many low-income countries. Long term risks for competition need to be monitored.

## 7. eHealth as a promoter of access and quality

The role of eHealth has been considered in some detail and it is observed that electronic developments

have been in operation for some time through computerisation of records and registrations, for example. The diminution of the distance barrier deserves recognition as a reinforcement rather than replacement of staff.

One WHO African region report expresses concern that the “bewildering array of choices, creates demands that tax limited resources.”<sup>106</sup> Things may have improved since then (2014), but one should still take note of this caution and the conclusion that, “there is a need for clear and comprehensive policies on health care technology” as eHealth is reaching the stage of consolidation and normalisation, with its benefits recognised, but many practical issues, for example, such as, local infrastructure, are still to be overcome to deliver its true potential.

Privacy is widely understood in health services and the prevalence of this, almost cultural, value is encouraging. However, the WHO Observatory of eHealth has uncovered a degree of confusion about the different forms of legislation, which divide roughly into generic and health specific. As with consumer protection law, there is of course a place for both horizontal and vertical legislation.

**Recommendation 7:** The development of eHealth is very beneficial especially in pandemic conditions following the approach taken by the WHO. Regarding privacy and data protection in health, legislation needs to incorporate both horizontal and vertical aspects, reviewing national privacy laws, with appropriate remedies for breaches and appropriate institutional safeguards such as data protection authorities, as well as specific protections for health records and confidentiality.

## 8. Role of identity mechanisms and link to eligibility

Guideline (5j) of the United Nations Guidelines for Consumer Protection sets out the “principle of equivalence” (as it has become known) under which consumers are entitled to the same level of protection on and off-line. This relates to a patient’s right to access to service irrespective of technology. This is of particular importance in the context of the use of electronic IDs. To the extent that contribution records and means tests are not to be the basis of entitlement, then that leaves identity as the main signifier, including the presence of children. That in turn raises the question of right to access to service irrespective of technology.

Evidence is emerging that systems of electronic/ biometric IDs which are meant to be voluntary are gradually becoming “digital by default.” There is a risk that this could turn into de facto discrimination against those for whom digital access is more difficult. The underlying entitlement should not vary.

Digital and biometric IDs can make identity for access much simpler. A further issue, however, is the distinction between identity and privacy. In the context of requests for universal service, identity becomes the key to access, rather than significant data in itself.

Once access is gained, the data contained in the system, such as health records, are highly sensitive not only “vertically” in terms of who has access within the health system, but also “horizontally” in that each system – health records, bank accounts, needs to be self-contained and secure against “leakage” if users are to retain confidence. It is also worth taking note of the recommendation in the ILO study cited earlier that a set of norms be established, while the development of biometric IDs is still under way. The paper calls for, domestic and international norms in social protection systems...

determining: (a) when (such) use is legal or non-arbitrary, (b) the rights of beneficiaries whose data, including biometric data, are processed, (c) the obligations of social protection authorities and other actors who process and control the information, and (d) the mechanisms that should be put into place to safeguard that information.<sup>107</sup>

The use of biometric IDs and electronic search functions could help bring about formalisation of the informal sectors (and settlements), possibly faster than expected, as happened with mobile telephony in Africa. There is a difficult balance to be established between the build-up of social registers which is urgently needed, while respecting privacy and not leading to another form of exclusion, for those who do not have such registration. This is not a matter of privacy as an abstract concept. If systems leak, or are used as forms of control, users may stay away from the services.

**Recommendation 8:** Consumers should be entitled to access to a service and equivalent treatment during service regardless of the whether their identity signifier is digital or other, with appropriate regulation available to protect the consumer, adopting core international principles of data protection.

## 9. Integration of informal sectors

Understanding is growing that the scale of the informal economy needs to be recognised and provision made for its workers who are often excluded from social protection mechanisms, particularly in Africa. The United Nations Secretary-General has urged that, “Social protection is urgently needed with a focus on the most vulnerable and marginalized urban groups, ... regardless of formality of work or migration status.”<sup>108</sup> Some Governments in the Arab world had already started to extend social protection to informal workers before the COVID-19 crisis struck.<sup>109</sup> There are also signs that recognition of the economic contribution made by the informal workforce has been sparked by COVID-19. There is a double challenge in not only supporting the informal sector workers in their urgent need, but also of employing their skills by developing services that will improve the health of the communities they serve.

The sheer size of the informal sector in the low- and middle-income countries makes contribution-based and income-tested models difficult, based as they are on some kind of record, either of earnings or of contributions or both.<sup>110</sup> Nevertheless, note should be taken of the ILO Recommendation 204 on formalizing the informal economy, which aims to bring the informal sectors within the coverage of the existing social protection systems. The speed with which this can be done varies between regions, for example, such is preponderance of informality in Africa that this will inevitably be a long process. In any event, designing new systems will be difficult, so the existing ones, will have to remain in place in those countries and/or sectors which still have functioning record-based systems, while new systems are designed for those who do not.

**Recommendation 9:** Entitlements to health services and direct income transfers need to be remodelled so as to bring the informal sectors into eligibility. Social registers could be updated and expanded using digital IDs with due privacy safeguards.

## 10. Consumer protection legislation during emergencies

The recent emergency market measures such as price freezes and suppression of foreclosures became more established as COVID-19 continued. To prevent consumer disasters, business collapse or both, one option is the high-level adoption of the legal concept of “force majeure” (i.e., the declaration of exceptional circumstances to justify the suspension or amendment of contractual obligations).<sup>111</sup> This would aim to fend off the “cliff-edge” moment when many of the moratoria on private contracts come to an end. Such mechanisms were applied in effect on a wide scale in the short term, even if not explicitly, because of the impracticability of enforcement of such items such as credit agreements or rental contracts. It became a matter of particular urgency that the issue of suspension or amendment of consumer obligations be addressed in the lower income countries where, for example, micro-finance agreements are widespread, and resources are scarcer.<sup>112</sup>

**Recommendation 10:** In the exceptional circumstances of the pandemic outbreak, an explicit declaration of “force majeure” by governments, duly noted by courts and regulators, would recognize and encourage the block renegotiations of consumer contracts. Statutory safeguards could be developed to limit arbitrary impositions and set down requirements for review.

The precise form and extent of the declarations will vary and this requires study at national level in different jurisdictions, but action is required quickly to forestall the overwhelming of civil justice systems and conceivably, widespread civil disorder which could otherwise result. Consumer protection agencies and possibly consumer associations could have an important role to play in this process. The consumer protection agencies could act as “honest brokers” in negotiating at scale, developing model block agreements and other examples of good practice.

## NOTES

- <sup>1</sup> United Nations, *Strengthening Social Protection for Pandemic Response*, UN COVID-19 response, 2020.
- <sup>2</sup> UNCTAD, Committee for the Coordination of Statistical Activities Volume III (2021), *How Covid19 is changing the world: A statistical perspective*, p. 32.
- <sup>3</sup> World Bank, *World Bank Group and Covid19*, Latest news, August 3, 2020.
- <sup>4</sup> Development Account 13 Project document, *Strengthening Social Protection for Pandemic Response*, 13/08/20.
- <sup>5</sup> United Nations, *Secretary-General's Policy Brief: Investing in jobs and social protection for poverty eradication and a sustainable recovery*, 28 September 2021, p. 9. NB: the four guarantees are: essential health care and basic income security for children, people of working age and older persons, respectively.
- <sup>6</sup> Consumers International (2020), See: <https://www.consumersinternational.org/> (accessed 26 March 2020).
- <sup>7</sup> United Nations, *The Sustainable Development Goals Report 2021*, p. 33.
- <sup>8</sup> UNCTAD, 2017, *Manual on Consumer Protection*, p. 4.
- <sup>9</sup> WHO, 2019, *Global spending on health: A world in transition*, Box 1.1.
- <sup>10</sup> F Bonnet, J Vanek, M Chen, WIEGO (2019), *Women and men in the informal economy: A statistical brief*, ILO 2019, providing definitions of the informal economy and summarising findings of *Women and men in the informal economy: A statistical picture*, ILO 2018; Informal sector is defined as consisting of “a subset of unincorporated enterprises not registered with a national governmental authority.” It does not include production for own consumption such as subsistence farming. Box 1.
- <sup>11</sup> United Nations, Policy brief, Covid19 in an urban world, July 2020, p. 3; Women are more vulnerable given their greater preponderance than men in the informal economy, especially in the low-income countries. For example, in urban areas of Ghana, women have been estimated to make up over 80 per cent of the 1.3 million market traders and street vendors; R Moussié and S Staab (source), *Three ways to contain COVID-19's impact on informal women workers*, UN Women newsletter, 18 May 2020.
- <sup>12</sup> ILO, *Recommendation 204 on transition from informal to formal economy*, 2015 Articles 10 and 11.
- <sup>13</sup> WIEGO, *Informal workers in the COVID-19 crisis: A global picture of sudden impact and long-term risk*, 2020, p. 14.
- <sup>14</sup> F Bonnet, et al, op. cit., p. 1.
- <sup>15</sup> UNCTAD (2017), *Manual on Consumer Protection*, chapter 15, United Nations, 2017; S Misra and W Kingdom, *Citywide Inclusive Water Supply: Adopting off-grid solutions to achieve the SDGs water global practice*, World Bank, 2019; D Mitlin and D Satterthwaite, *Urban poverty in the global south*, IIED 2013; and R Subbaraman, J O'Brien, T Shitole, S Shitole, K Sawant, D Bloom, and A Patil-Deshmuk, *Off the Map: The health and social implications of being an unrecognised slum in India*, 2012, IIED, Environment and Urbanisation, 23:1.
- <sup>16</sup> L Alfes, R Moussié, J Harvey, (2020), *The COVID-19 Crisis: Income support to informal workers is necessary and possible*, OECD Development Matters, (22/04/20).
- <sup>17</sup> Women in Informal Employment: Globalizing and Organizing, WIEGO (2020), *Informal Workers in the COVID-19 Crisis: A global picture of sudden impact and long-term risk*, 2020, pp. 14-24.
- <sup>18</sup> UNCTAD, *Manual on Consumer Protection*, chapter 15, United Nations 2017, S Misra and W Kingdom, op. cit. 2019; D Mitlin, and D Satterthwaite, op. cit., IIED 2013, pp. 64-66; R Subbaraman, et. al., op. cit., 2012.
- <sup>19</sup> The issues around informal service provision is discussed in the publication by UNCTAD, *Access by consumers to essential services: Energy, water and sanitation*, United Nations, 2022.
- <sup>20</sup> ECLAC, *The social challenge in times of COVID- 19*, Concept Note 2020, p. 18.
- <sup>21</sup> UNGA Resolution 2200A (XXI) of 16 December 1966.
- <sup>22</sup> Committee on Economic, Social and Cultural Rights, Twenty-second session Geneva, 25 April – 12 May 2000, General Comment No. 14 (2000), *The right to the highest attainable standard of health (article 12 of the International Covenant On Economic, Social and Cultural Rights)*.

- <sup>23</sup> UNCTAD, 2016, available at: [https://unctad.org/system/files/official-document/ditccplmisc2016d1\\_en.pdf](https://unctad.org/system/files/official-document/ditccplmisc2016d1_en.pdf).
- <sup>24</sup> On the implementation of the UNGCP see, *Implementation of the United Nations Guidelines for Consumer Protection*, by The UNCTAD secretariat (TD/RBP/CONF.9/2, 8 July 2020) regarding the period 2015-2020, and Implementation Report on the United Nations Guidelines on Consumer Protection (1985–2013) by the UNCTAD secretariat (TD/B/C.I/CLP/23, 29 April 2013), available at: <https://unctad.org/Topic/Competition-and-Consumer-Protection>. The Guidelines were first adopted by the General Assembly in resolution 39/248 of 16 April 1985, later expanded by the Economic and Social Council in resolution, E/1999/INF/2/Add.2 of 26 July 1999, and recently revised by the General Assembly in resolution 70/186 of 22 December 2015.
- <sup>25</sup> See for example, UNCTAD News 08/04/20 Covid19, *Firmer action needed to better protect consumers*, UNCTAD April 2020, *UNCTAD and consumer protection in the time of Covid19*.
- <sup>26</sup> *United Nations Guidelines for Consumer Protection*, adopted as Annex to resolution adopted by the General Assembly 22/12/2015, Res/70/186.
- <sup>27</sup> UNCTAD, *Manual on Consumer Protection*, United Nations, 2017.
- <sup>28</sup> [www.unctad.org](http://www.unctad.org). “Group-of-experts-consumer-protection” - the IGE is a standing body established under the UNGCP to monitor their application and implementation, provide a forum for consultations, produce studies, provide technical assistance, undertake voluntary peer reviews, and periodically update the Guidelines.
- <sup>29</sup> UNCTAD, *Achieving the Sustainable Development Goals through Consumer Protection*, United Nations, 2017.
- <sup>30</sup> Also discussed in UNCTAD (2022), *Access by consumers to essential services: Energy, water and sanitation*, United Nations, 2022.
- <sup>31</sup> The global indicator list is contained in the *Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators* (E/CN.3/2016/2/Rev.1), Annex IV.
- <sup>32</sup> UNCTAD, *eTrade for all, eTrade Readiness Assessments of land-locked developing countries*, 2019.
- <sup>33</sup> UNCTAD, *Information Economy Report 2015: Unlocking the potential of E-commerce for developing countries*; UNCTAD, Digital Economy Update, *The COVID-19 crisis: Accentuating the need to bridge digital divides*, UNCTAD/DTL/INF/2020/21, 6 April 2020; ESCWA: Economic and Social Commission for Western Asia (ESCWA) E/ESCWA/30/17 19 April 2018, *Technology for Sustainable Development: Creating decent jobs and empowering youth in Arab countries*; ESCWA Arab Digital Development Report: *Towards empowering people and ensuring inclusiveness*, E/ESCWA/TDD/2019/6 and Issued in 2020; UNCTAD, *Data protection regulation and international data flows: Implications for trade and development*, 2016.
- <sup>34</sup> The “legitimate needs” are often known as “consumer rights,” although that term does not figure in the UNGCP, and they are not legally enforceable unless written into national legislation. They are widely cited in debates on policy and law.
- <sup>35</sup> UNCTAD, available at: <https://unctad.org/topic/competition-and-consumer-protection/un-guidelines-for-consumer-protection>.
- <sup>36</sup> T Bourgoignie, *Protection du consommateur et protection du patient: Complémentarité des systèmes de protection*, Salvador, Bahia, Brazil, 27 September 2017; See also: T Bourgoignie, *Accidents thérapeutiques et protection du consommateur*, Edition Yvon Blais Quebec, 2006.
- <sup>37</sup> UNCTAD (2017), *Achieving the SDGs through Consumer Protection*, United Nations, p. 2.
- <sup>38</sup> DH Peters, A Garg, G Bloom, DG Walker, WR Brieger, M Hafizur Rahman, (2008), *Poverty and access to health care in developing countries*. Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, United States of America, Institute of Development Studies, Sussex, United Kingdom, 2008.
- <sup>39</sup> UNCTAD (2016), *Dispute resolution and redress*, Note by the secretariat, TD/B/C.I/CPLP/11paras 12 and 13, 2016.
- <sup>40</sup> UNCTAD (2017), *Manual on Consumer Protection*, United Nations, 2017, p. 89. The term ‘Ombudsman’ originated in this context in Scandinavia and was widely adopted elsewhere during the late 20th century. An equivalent term in Latin America is ‘El Defensor del Pueblo’ more recently, the Ombudsman concept has extended to the private sector.
- <sup>41</sup> UNCTAD, Australian Aid, ASEAN (2016), *Health Care Services*; Project on Strengthening Technical Competence for Consumer Protection in ASEAN, 2016.



- <sup>42</sup> *Dispute resolution and redress*, Note by the UNCTAD secretariat, TD/B/C.I/CPLP/11, Intergovernmental Group of Experts on Consumer Protection Law and Policy, Geneva, 9 and 10 July 2018.
- <sup>43</sup> WHO, *Global spending on health: A world in transition*, WHO, 2019, Box 1.1
- <sup>44</sup> K Dickson, K Hinds, H Burchett, G Brunton, C Stansfield, J Thomas, (2016), *No Fault compensation schemes: A rapid realist review to develop a context, mechanism, and outcomes framework*, UK Dept of Health Reviews Facility, 2016.
- <sup>45</sup> WHO, *Global spending on health: A world in transition*, WHO, 2019, op. cit., p. 6.
- <sup>46</sup> WHO, *Global spending...* 2019, op. cit., pp. ix,5 and 7.
- <sup>47</sup> WHO, *Global spending...* 2019, op. cit., Fig. 1.7.
- <sup>48</sup> WHO, *Global spending...* 2019, op. cit., Fig 1.7 NB: Box 1.1, Out-of-pocket spending (OOPS) is a payment by households directly to providers to obtain services and health products. It includes purely private transactions (individual payments to private doctors and pharmacies), official patient cost-sharing (user fees / co-payments) within defined public or private benefit packages, and informal payments (payments beyond what is prescribed within benefit entitlements, both in cash and in kind). Thus, OOPS can occur as an explicit part of policy or simply through market transactions, or both.
- <sup>49</sup> WHO, *Global spending...* 2019, op. cit., p. x.
- <sup>50</sup> WHO, *Global spending...* 2019, op. cit., p. 27.
- <sup>51</sup> WHO, *Global spending...* 2019, op. cit., p. 32.
- <sup>52</sup> WHO, *Global spending...* 2019, op. cit., p. 30.
- <sup>53</sup> WHO, *Global spending...* 2019, op. cit., p. 28.
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- <sup>79</sup> Data protection relates to “security” as in protection against hacking and illegal entry into databases. “Confidentiality” is about sharing and disclosing information on an authorised basis and long predates the current digital developments although, of course, the issue is intensified by recent technological changes.
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- <sup>82</sup> Human Rights Council A/HRC/41/39/Add.1 Distr.: General 23/04/19, *Visit to the United Kingdom of Great Britain and Northern Ireland Report of the Special Rapporteur on extreme poverty and human rights*.
- <sup>83</sup> The Pan-American Health Organisation (PAHO) reported in 2021 that many telecommunication services that work for health services are carried out on “non-smart” cell phones. PAHO/WHO, (2021), *Connectivity and Bandwidth: Key areas for improving public health*, Digital Transformation toolkit, Knowledge tools, pp. 2-4.
- <sup>84</sup> United Nations, *Policy Brief, The impact of Covid-19 on SE Asia*, July 2020, p. 6.
- <sup>85</sup> UNCTAD, Digital Economy Update: *The COVID-19 crisis: Accentuating the need to bridge digital divides*, UNCTAD/DTL/INF/2020/21, 6 April 2020.
- <sup>86</sup> Groupe Spéciale Mobile Association (GSMA), *The Digital Lives of Refugees: How displaced populations use mobile phones and what gets in the way*, 2019.
- <sup>87</sup> *G20 Digital Identity Onboarding*, World Bank Global Partnership for Financial Inclusion, 2018. See Box 6 case studies of Peru, India, Pakistan.
- <sup>88</sup> *G20 Digital Identity Onboarding*, p. 28.
- <sup>89</sup> United Nations News: *COVID-19: Countries support “one-stop shop” to share science and research*, United Nations News, 29/05/20, and “*Landmark collaboration” to make COVID-19 testing and treatment available to all*, United Nations News, 27/04/20.
- <sup>90</sup> UNCTAD, *COVID-19: Firmer action needed to better protect consumers*, 08/04/20.
- <sup>91</sup> ICPEN in UNCTAD, *Competition and consumer protection in the time of COVID-19*, April 2020.
- <sup>92</sup> Report to webinar convened in Beirut August 3rd, 2020, by UN Economic and Social Commission for West Asia.
- <sup>93</sup> *Business Daily* March 16 2020, Kevin Rotich, *Competition Authority orders Cleanshelf to refund customers for inflating hand sanitiser prices*.
- <sup>94</sup> *FCCPC forces Jumia to delist 390 products* March 9, 2020. It should be noted that Jumia cooperated immediately and continued to monitor those selling on its platform.
- <sup>95</sup> Olivier Angaman, Director of Competition, WAEMU, *the experience of regional organisations in competition and consumer protection*; UNCTAD webinar 17/06/20 *Key competition and consumer protection priorities for regional integration in Africa*.

- <sup>96</sup> Regarding the last example, face masks have proved to be a successful example of production by informal workers, working to agreed standards under contract to local agencies. This has happened in Ethiopia and Kenya where VAT has also been reduced for masks. Source: WIEGO, *Informal workers in the COVID-19 crisis: A global picture of sudden impact and long term risk*, 2020.
- <sup>97</sup> In most jurisdictions, dominant position is not *per se* a breach of competition law, it is the abuse of such a position which leads to intervention.
- <sup>98</sup> Brussels, 8.4.2020 C(2020) 3200 final Communication from the Commission, Temporary Framework for assessing antitrust issues related to business cooperation in response to situations of urgency stemming from the current COVID-19 outbreak; UNCTAD *Competition and Consumer Protection in the time of Covid19 April 2020*.
- <sup>99</sup> UNCTAD, *COVID-19 firmer action needed to better protect consumers*, April 2020.
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- <sup>101</sup> COVID-19 Consumer Law Research Group, *op. cit.*
- <sup>102</sup> *Código de Protecção e Defesa do Consumidor, Edição comemorativa, 25 anos da lei*. Secretaria Nacional do Consumidor, Ministério da Justiça, (SENACON) 2015; For a detailed analysis in French, P Galindo da Fonseca, *Droit de la Protection du consommateur au Québec et au Brésil : une analyse comparée*. Editions IEIM 2016, Montréal; In English see: C Lima Marques and P Galindo da Fonseca, *Consumer protection in Brazil: The 2016 Report for the International Academy of Consumer Law*, in: *Enforcement and effectiveness of consumer law*, H-W Micklitz, G Saumier, (eds.), Springer 2018, p. 100.
- <sup>103</sup> WHO, *Global spending on health: A world in transition*, 2019, *op. cit.*, p. 30.
- <sup>104</sup> WHO, *Global spending 2019*, *op. cit.*, Box 1.1.
- <sup>105</sup> D Clarke, “Law, Regulation and Strategizing for Health,” found in: G Schmets, D Rajan, and S Kadandale, (eds.), *Strategizing National Health in the 21st Century: A Handbook*, World Health Organization, Geneva, 2016, Chapter 10, available at: <https://www.who.int/publications/i/item/9789241549745>
- <sup>106</sup> WHO, *The African Regional Health Report*, 2014, p. 123.
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- <sup>108</sup> United Nations policy brief, *Covid19 in an urban world*, July 2020, p. 25.
- <sup>109</sup> United Nations policy brief, 2020, *op. cit.*, p. 26.
- <sup>110</sup> The very term “informal sector” may be misleading as it may have connotations of illegality. Informal working is simply unrecognised and not integrated into systems of taxation and social security. Rural areas may be functioning as economic zones but not commercialised, while peri-urban slums may lack official recognition having developed extremely rapidly.
- <sup>111</sup> Covid19 Consumer Law Research Group, *Consumer Law and Policy Relating to Change of Circumstances Due to the COVID-19 Pandemic*, Journal of Consumer Policy, 43.03/08/202.
- <sup>112</sup> Tunisia has invoked existing provisions for “force majeure” regarding the development of more flexible arrangements for public procurement during the pandemic; OECD, *COVID-19 crisis response in MENA countries*, (update 06/11/20).



