Globalization

World trade: bringing health into the picture
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What implications do the new multilateral trade agreements have for health and well-being? The relationship needs to be understood in order to put trade and health objectives into proper perspective. This introductory article looks at some of the areas in which international trade and public health interact.

As recurring outbreaks of foodborne diseases – in some cases from imported foodstuffs – attract increasing public attention, awareness is growing that international trade is a matter that no longer concerns solely ministries of trade or finance. Welcome or not, public health input is being increasingly solicited in a domain which is new to many health professionals.

Expanding world trade is affecting everyone’s lives, from the consumers who see new imported goods in the shops to governments in the developing world which may be counting on increased foreign exchange to sustain growth. Supporters of free trade see this development as a step towards a more efficient allocation of resources worldwide, leading to increased incomes and better living conditions for all involved. Others have strong doubts as to whether all countries and population groups will benefit equally: there are indications of increasing marginalization for some. How relevant is this debate to the health sector?

First, trade liberalization per se is linked neither to better nor to worse public health conditions. Yet – especially for developing countries – it has the potential to provide opportunities for improving health status of the individual and the community. Increased trade should mean more employment opportunities and higher wages, so that people can afford better food and health care for themselves and their families. Governments can use additional revenues stemming from export earnings to improve both public health services and other health determinants such as education, sanitation and housing. In turn, better health status enhances the quality of labour and raises productivity.

A traditional and somewhat narrow view holds that a social sector such as health, when compared to the productive sectors – agriculture, extractive industries,
manufacturing or services – merely absorbs resources, even if they are well spent. However, that would overlook the quantifiable contribution that public health action, in particular national regulatory frameworks, makes to improving a country’s export possibilities. For exam-

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...ple, the joint efforts of health authorities and local cattle producers in Chile, Uruguay and other parts of South America to eliminate foot-and-mouth disease were outstandingly successful, and these countries have now been recognized as free of the disease. As a result, importing countries have been able to lift certain sanitary barriers to trade, and new international markets have opened up to meat products. For instance, after Uruguay was recognized free of foot-and-mouth disease without vaccination in 1996, the volume of beef exports rose by 36% in the first six months of that year (1).

Conversely, breakdowns in disease control have implications that exceed public health considerations alone. For example, India is estimated to have lost some US $1700 million in exports, tourism and transport services because of a recent epidemic of plague (2), not to mention the United Kingdom’s estimated trade loss running to billions of dollars since its European partners banned imports of British beef because of the suspected link between bovine spongiform encephalopathy and new variant Creutzfeldt-Jakob disease. Such events are making the interaction between public health action and international trade increasingly clear.

**An age-old link**

Centuries ago people realized that there was a link between the health situation and trade flows. As Professor Fidler points out in a recent article (3), the conscious linking of trade and health dates back at least to the fourteenth century, when Italian city-states began to develop quarantine systems to guard against the importation of bubonic plague, which they believed came to them through trade.

When the major international organizations were set up some 50 years ago, the founders recognized that linkage. The original General Agreement on Tariffs and Trade (GATT), established in 1947, makes provisions for countries to apply measures “necessary to protect human, animal or plant life or health”, if they do not unjustifiably discriminate between countries where similar conditions prevail, or act as a disguised restriction to trade (4). For its part, the World Health Assembly, back in 1949, called attention “to the need for eliminating quarantine restrictions of doubtful medical value which interfere with international trade and travel” (5).

**A symbolic link**

The classical symbols for medicine and commerce are very similar. The first is the staff of Aesculapius, the Greek god of medicine, which has one snake curling around it (as in WHO’s logo). The second is the staff carried by Mercury, the Roman god of merchants, which has two snakes twined around it, beneath a pair of wings. The two are often confused.
Hence, the fundamental principle of the International Health Regulations – one of WHO’s two instruments that legally bind Member States – is to ensure maximum security against the international spread of diseases with minimum interference with world traffic and trade. The precept is retained in the current proposed revision of the regulations (6).

So there is a reciprocal understanding that health must be protected over and above business interests, but that protection measures should not intrude on commerce without justification.

**The new trade environment**

The conclusion of the Uruguay Round of multilateral trade negotiations in 1994 helped to push world trade into the limelight. A new international organization came into operation: the World Trade Organization (WTO). Its function is to provide the legal and institutional foundation of the multilateral trading system. Unlike the organizations of the United Nations system, whose mandates include implementation of technical cooperation programmes with developing Member States in specific sectors, such as agriculture or education, WTO’s essential functions are to administer and to ensure the smooth application of the 19 international trade agreements resulting from the Uruguay Round. At the same time it provides a forum for trade negotiations, seeks to resolve trade disputes, oversees national trade policies, and cooperates in global economic policy-making (7).

The driving force behind recent expansion of trade has been the new trade agreements issuing from the Uruguay Round. They have extended the rules governing commercial relations between trading partners to a number of new areas, such as agriculture, services, investment measures, and the protection of intellectual property, that were previously excluded from the trade liberalization process. Several of these agreements have direct implications for health sector activities, hence both for WHO’s normative functions and for its technical cooperation.

**Where public health comes in**

How do these agreements affect the health sector? Can public health concerns in turn help to shape trade regulations? In the following paragraphs we briefly review the new trade agreements that are most relevant for the health sector, related to the application of internationally agreed quality and safety standards, the strengthening of intellectual property rights, and the opening up of trade in services, as indicated in the table on page 400 (8).

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They lead us to consider some examples of the increasing number of trade disputes that have a public health content, and to conclude with some of the efforts being made to introduce health concerns into trade negotiations. This short article cannot cover all the issues involved, but information on such longstanding problems as trade in harmful substances like tobacco or toxic wastes may be found elsewhere in WHO literature.
**Main WTO agreements with implications for the health sector**

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**Food production: safety first**

Possible use of health protection measures to restrict trade had been a concern since the beginning of multilateral trade negotiations. However, it was nearly 50 years before trading partners concluded the Agreement on the Application of Sanitary and Phytosanitary Measures (SPS) that responded specifically to the fear that, as other trade barriers came down, measures of this kind might be used for protectionist purposes. So the Agreement guides their application so as to minimize any negative effect on trade. Such measures must be based on risk assessment and supported by scientific evidence, and countries are encouraged to harmonize them on the basis of international standards. In the case of food safety, the Agreement recognizes that the international reference is the set of standards, guidelines and recommendations relating to food additives, veterinary drugs and pesticide residues, contaminants and others drawn up by the Codex Alimentarius Commission – which implements the Joint FAO/WHO Food Standards Programme.

As low-income countries, especially, start to move up the “export ladder”, one of the first value-added industries is often food processing – a highly competitive market worth more than US $250,000 million a year. In that context, what could be more important for them than to be able to offer consumers products that are safe and of good quality, or more devastating than the consequences of outbreaks of foodborne diseases? Yet expanding trade also increases the risk of transmitting those diseases, not only from the movement of products, but also from the

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multinational approach to food production, manufacturing and marketing (9).

In a context increasingly governed by private sector participation, and a market in which quality is bound to become one of the most valuable tools for competition, there is an overriding need for universally accepted standards. The mechanism geared precisely to facilitating fair trade in food while protecting the health of consumers is the Codex Alimentarius Commission. If local food industries, with the support of the health sector, apply the Codex norms, the food they produce and process is safe for consumption and acceptable for export. So countries – especially the developing ones – are encouraged to participate directly in the work of the Commission to ensure that future texts are consistent with their health and safety requirements and supportive of their food export industry (10).

Ensuring pharmaceutical quality

Food products are only one example of how health protection can improve trade potential. Another is pharmaceuticals – again a market in which product quality and safety are crucial for consumers’ health, and in which commercial interests are huge. A number of middle-income countries have developed their own industries in this sector, serving both domestic and foreign markets. WTO’s Agreement on Technical Barriers to Trade (TBT) encourages Members to apply internationally agreed standards as a basis for their technical regulations, but unlike the SPS agreement, it does not identify them. None the less, the application of such standards as WHO’s good manufacturing practices enables firms to produce quality goods that are acceptable for export and safe for consumers.

For their part, importers can seek assurance that goods are produced in accordance with these standards through WHO’s certification scheme on the quality of pharmaceutical products moving in international commerce. Countries of the European Union have been issuing these certificates for nearly 10 years in accordance with an EEC directive, and all WHO Members are now urged to issue and request certificates in the prescribed form as from the beginning of 1998 (11).

WHO’s good manufacturing practices for biological substances, such as vaccines and blood products, and recommended requirements for their preparation, are also intended to help manufacturers produce quality goods. Purchasers – at home or abroad – might request manufacturers to comply with WHO’s production and quality control requirements to be sure that the product is safe and effective. A number of developing countries that produce certain basic vaccines for the domestic market and export their surplus, find these norms particularly useful.

However, since TBT covers a very broad range of products, the agreement does not specify the international standards to be taken as a reference. Should a trade dispute arise involving biologicals, the WTO dispute settlement panel might have to take a decision on which standards should apply to that case. They could be WHO’s guidelines and requirements – or the norms of another standardizing body. Hence there is some uncertainty as to what might happen in a dispute concerning, for example, vaccines, for which manufacturers have in some cases differing, yet equally valid, standards.
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Will access to pharmaceuticals be affected by patent protection?

A quite different health concern from quality and safety standards has been raised by WTO’s Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). Intellectual property rights have long been protected by several specific conventions. Since the establish-

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ment of the World Intellectual Property Organization in 1967 they have been administered by a single body, which also works on harmonizing national legislation. However, rights could not always be strictly enforced. TRIPS, which essentially establishes minimum standards for the protection of different forms of intellectual property, fills that gap because such protection has to be incorporated into national legislation and can be enforced internationally through trade sanctions. Patents, for example, will be available for any new industrially applicable invention, in all fields of technology. This means that, for the first time, in all WTO Member States, pharmaceuticals will be subject to patent laws.

Stronger patent protection should be an incentive for pharmaceutical companies to invest in drug development, but the big question – especially in developing countries – is: what will be its long-term effect on drug prices? How affordable will new patented medicines be as pharmaceutical companies recoup their research and development costs? Although generic – “off-patent” – drugs are by nature excluded from this new legislation, will poor countries continue to have access to low-cost, safe and effective essential drugs, especially new ones? These are some of the questions that WHO is currently examining in connection with the possible impact of applying TRIPS provisions on patent protection.

Even more questions arise over substances that derive from the application of biotechnology, involving such processes as gene transfer, cell manipulation, or recombinant DNA technology. Such techniques are helping to increase the availability of, for example, therapeutic human proteins, antibiotics, purified blood products, or new and improved vaccines. But the TRIPS provision concerning biotechnology is subject to debate. It does not specify, for example, if replication of a naturally existing gene for a human protein should be patented or not, so is open to different interpretations. Some countries accept the view that such a substance can be patented if and when it is produced and isolated in a purified form from a foreign cell. Others maintain that in this case there is no “invention”, simply a “discovery” that cannot form the basis for claiming intellectual property rights. The issue has implications for countries that produce drugs and vaccines based on substances existing in nature, or plant-based medicaments. It should be elucidated shortly when the provision is revised.

Trade throws a new light on health services

Trade in products, however, is only part of the picture. Services – activities such as banking, insurance, transport or tourism – now represent a vast portion of global trade. The Uruguay Round made a start at
bringing them under similar trade regulations to those affecting goods, the outcome being the General Agreement on Trade in Services. In the context of the health sector, these services include care provided to patients who travel abroad for treatment, foreign direct investment in the health sector, services provided across borders, such as telemedicine, services provided abroad by expatriate health professionals, or medical training provided to foreign students.

Trade in health services is a relatively new and fast growing phenomenon, which has considerable potential as a foreign exchange earner for developing countries (12). In the new trade environment, the health sector itself may be an entrepreneur, bringing in revenues not only from health care as such, but also from nonmedical domains, such as health and fitness tourism. In future we may see a shift in the consumption of health services abroad towards developing countries that can offer quality care at lower cost. A number of these countries, such as Cuba, India and Jordan, have been making a considerable investment to upgrade their human and physical health resources in order to attract foreign patients, taking advantage not only of their natural endowments, but also of their often highly qualified health personnel. Yet the question remains, are these activities compatible with a country’s own health sector objectives, such as ensuring access for everyone to sound and efficient care?

**How trade disputes can affect consumers**

What happens when trading partners disagree over an issue involving health? To whom do they turn for impartial scientific evidence? WTO has established a procedure for settling trade disputes, if parties cannot reach a negotiated solution. A panel of three qualified people, acting in their individual capacities, is set up to examine the complaint and to make findings that will lead to a recommendation or ruling. If a party raises a scientific or technical matter, the panel may appoint an expert review group to provide an advisory report. It is at this stage that WHO may be called upon to provide expert advice in disputes involving a public health issue. Once a recommendation or ruling has been drawn up and parties have had an opportunity to appeal, the final report is accepted by WTO Member States (7).

In this context, however, the overriding logic for a decision is that of the principles of free trade, not of public health. For example, a dispute arose several years ago, when Thailand refused to lift its restrictions on imports of foreign cigarettes as requested by the United States. It invoked, among other GATT provisions, its right to enforce measures necessary to protect human health. WHO experts provided information on various factors that contributed to low tobacco consumption in Thailand. The panel agreed that measures were needed to protect health, but recommended that Thailand should abolish restrictions on cigarette imports while applying pricing and taxation regulations equally to domestic and foreign brands.

In a number of developing countries, a ruling like this has adversely affected national tobacco control programmes. Thailand, however, wisely offset the potential impact by taking appropriate public health measures based on WHO’s recommendations for comprehensive tobacco control. It particular, it maintained a ban on all cigarette advertising. In this way, the number of smokers in the
population has remained remarkably low, and even declined among some groups.

Two recently concluded cases concerned the use of hormonally active substances as a growth promoter in cattle. The European Union had banned imports of meat if those substances had been used in rearing. Both Canada and the United States filed complaints against this prohibition. The Joint FAO/WHO Expert Committee on Food Additives – an advisory body to the Codex Alimentarius Commission – had some 10 years ago concluded that “residues resulting from the use of [these substances] as growth promoters in accordance with good animal husbandry practice are unlikely to pose a hazard to human health” (13). This evaluation had provided the basis for the relevant Codex standard, which was challenged by the European Union. WHO provided expert advice on the assessment procedures used to determine potential risk to human health. In the end, the dispute settlement panel and the subsequent appellate body both found that the prohibition was inconsistent with the relevant articles of SPS, in other words, that the European Union had not conducted appropriate risk assessment or provided scientific evidence to support its ban.

A third issue, which has given rise to several disputes in the area of pharmaceuticals, is compliance with the TRIPS provisions concerning patent protection. Complaints have been filed by the European Union against Canada and India, and by the United States against India, Pakistan and Portugal. The United States has reached an agreement with the other party in its three disputes; the cases brought by the European Union are still under way.

In short, the number of disputes will probably rise in parallel with expanding trade, and some will certainly be related to public health. Impartial scientific expertise in public health matters, such as can be provided by WHO, is likely to become increasingly useful during the settlement procedures.

**Introducing health concerns in trade negotiations**

With new public health questions continuously arising in relation to the trade agreements, answers will have to be found in a context which for many is quite different from the epidemiological setting in which they are used to framing health policy. And these concerns are but part of the much larger set of issues stemming from globalization, which embraces not only international flows of goods and services, but also of capital, working people, technology and information. In the increasingly interlinked world economy the demarcation between sectors of activity tends to blur. This is why the social sectors have to be aware of what is happening elsewhere, and prepared to work in ways and with associates that might have seemed counter-intuitive only a few years earlier.

What is important is to anchor health concerns firmly in the trade picture, introducing them at an early stage, when trade agreements are negotiated. For this reason WHO is building up its formal relations with WTO, which currently involve observer status on the SPS and TBT committees. WHO’s regional offices are active in promoting discussion and agreement on health and related matters within regional trade groups, such as those in Latin America or South-East Asia.
Efforts are beginning to bear fruit. WHO/PAHO, for example, notes how those groups are paying increasing attention to health and social concerns. Even at the level of the hemisphere, the concept is gaining ground. At the Miami summit in 1994, when heads of State in the Americas agreed to negotiate the Free Trade Area of the Americas by 2005, they made a commitment to social objectives such as equitable access to basic health services. Recent follow-up meetings have recognized the importance of studying social implications and of giving formal status to health concerns.

In turn, national health sectors can back up these efforts if they realize the relevance to them of international trade and the need to participate as a valid and credible actor in a domain usually considered the remit of other areas of government. In this way, the sector should be able to take advantage of new opportunities for improving public health standards. In view of its contribution to ensuring that traded goods are safe for consumers, part of trade revenues could be channelled to improving people’s health and living conditions and to strengthening health regulatory frameworks. These are particularly important considering the composition of export activities in developing countries – agriculture, extractive industries, manufacturing and processing – which call for special attention both to occupational and to environmental health. It should be easier, for example, to introduce more stringent health standards in new exporting activities, where the cost structure can more easily accommodate additional expenses for health objectives.

The interaction between health and trade should be a two-way process from which both sides benefit. But, as the Director-General of WHO said at a meeting of the Group of 77 and China in 1996, “we must guard against the risk of commercial interests taking precedence over people’s health”. Thus health sector involvement in trade is fundamentally geared to maximizing the social benefits to be gained from trade, while containing any social cost. There can be only one objective: to ensure that the health status of the population improves as the economy grows.

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References
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The many facets of the environment

Health cannot be seen in a vacuum; it is determined to a great extent by environmental conditions. Environments are not just the visible structures and services surrounding us but have spiritual, social, cultural, economic, political and ideological dimensions as well. Furthermore, all the different facets of life are interwoven and inseparable. Influencing one will bring about changes in others, for better or for worse. Yet if healthy social development is to be maintained (not just promised during an electoral campaign of facilitated by time-limited foreign aid programmes), the environment must be targeted for change. This is what is known as sustainable development.