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Globalization, Trade and Public Health: Tools and Training for National Action

Report of an Intercountry Expert Group Meeting
New Delhi, 12–14 December 2000

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CONTENTS

ACRONYMS USED IN THE REPORT

AFTA	ASEAN Free Trade Area
ASEAN	Association of South East Asian Nations
CBD	Convention on Bio-Diversity
Codex	FAO/WHO Codex Alimentarius Commission
FAO	Food and Agricultural Organization of the United Nations
FCTC	Framework Convention on Tobacco Control
GATS	General Agreement on Trade in Services
GATT	General Agreement on Tariffs and Trade
GPGs	Global Public Goods
GPGH	Global Public Goods for Health
HIV/AIDS	Human Immuno-deficiency Virus/ Acquired Immuno-Deficiency Syndrome
IHR	International Health Regulation
IPRs	Intellectual Property Rights
MoH	Ministry of Health
MoT	Ministry of Trade
NGOs	Nongovernmental Organizations
R&D	Research and Development
SAARC	South Asian Association for Regional Cooperation
SEARO	Regional Office for South-East Asia of WHO
SPS	Agreement on the Applications of Sanitary and Phytosanitary Measures
TBT	Agreement on Technical Barriers to Trade
TM	Traditional Medicine
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WIPO	World Intellectual Property Organization
WTO	World Trade Organization

1. BACKGROUND

Globalization is a major driving force in development. Many national and international development dialogues have focused on the positive and negative effects of globalization, including trade liberalization on health and health care. Globalization is a mixed blessing. As consequences of globalization and trade liberalization, economic growth and technology advances are accelerated and this has contributed to great improvement in the health of the world population. On the other hand, several aspects of globalization are jeopardizing the health of populations and increasing the gap in health inequality within and between countries. Millions of people in the world currently have been left out of the health benefits of globalization. Over the years, WHO has been addressing these issues at many international and national forums and debating on issues relating to the implications on health. Many countries in the Region are adopting an open market approach with the trade liberalization policy. While globalization and trade liberalization have implications for health, a consensus on the mechanisms by which they affect the health of populations and pathways for the protection of health has remained elusive.

With this background, the WHO Regional Office for South-East Asia, in collaboration with WHO headquarters, organized an intercountry expert group meeting on "Globalization, Trade and Health: Tools and Training for National Action", at the WHO Regional Office, New Delhi from 12-14 December 2000. Senior public health specialists, economists, researchers, and country representatives from commerce and food and drug administration and ministries of health from four countries, which are implementing WTO Agreements (i.e. India, Indonesia, Sri Lanka and Thailand), attended the meeting. Technical experts from WHO headquarters, the Regional and Country Offices, representatives from the World Trade Organization, Geneva, the UNICEF Regional Office for South Asia, Kathmandu, also attended the meeting. (see Annexes 1 and 2 for the Programme and the Detailed List of Participants respectively).

The objectives of the meeting were:

(1) To analyse the effects of globalization and multilateral trade agreements on health risks and health service at national, regional and global levels, and

(2) To discuss the national actions to be taken, ensuring public health and focusing on training and research.

Inaugurating the meeting, Dr Uton Muchtar Rafei, WHO Regional Director for South-East Asia, stated that health products and health services being tradable, multilateral trade agreements had many positive and negative implications for health. As more goods and people travelled across continents, health was being affected more than ever. In order to ensure that globalization and international trade liberalization resulted in the betterment of health, efforts were necessary to protect the interests of public health. The active role of ministries of health or allied ministries responsible for the health sector in every country was essential. In fact, national authorities were the main actors and participants in the globalization efforts and international trade negotiations. He said that WHO should initiate training for health personnel in collaboration with other agencies and training institutions. Such training could be conducted initially on selective health-related issues in globalization and international trade. Another priority area in globalization and trade issues was the development of standards, norms and guidelines, including tool-kits, so that each country became capable of using them to analyze the positive and negative aspects of globalization and trade on health.

Professor Dr M. Achmad Djoyosugito (Indonesia) was nominated as Chairperson of the meeting and Mr Ashwani Kumar (India) as Vice-chairperson. Associate Professor Siripen Supakankunti (Thailand) was nominated as Rapporteur.

2. DELIBERATIONS ON SELECTED ISSUES

2.1 Globalization, Trade and Health

Globalization refers to three distinctive and interrelated phenomena: (a) increasing cross-border flows of goods, services, money, people,

technology and ideas; (b) opening of national economies and boundaries to such flows; and (c) development of international institutions and rules governing these cross-border flows. All the above three phenomena strongly influence and are affected by national macroeconomics and social policies, regulatory environments and institutions. These also have close linkages with health outcomes in four distinct areas such as health risks, health systems, level and distribution of household income, and impact on other sectors.

The spread of communicable diseases, both food-borne and non-food borne, illustrates the direct effects of globalization on health. The growth in international travel with more than two million people crossing international borders each day has contributed to carrying diseases into new areas. Trans-nationalization of markets and promotion of harmful commodities is also one important component of public health threats. Multinational tobacco companies are exploiting the potential for increased tobacco sales in the developing world and consumption is increasing among young adults, particularly men, in most developing countries.

Globalization may help countries to scale up effective public health interventions. It could also make positive and negative impacts on health systems in many other areas, such as government budget for health, access to health goods and products (drugs, vaccines, medical supplies, etc.), international mobility of health care services, and influencing knowledge on policies. It could make an impact on the government's ability to provide health care, especially in developing countries where the expenditure on health and education has remained static in real terms. A large part of the world population still has limited access to essential drugs, and since the legislation on intellectual property rights under the TRIPS Agreement extends patent protection to drugs, health situation may be further affected in many developing countries.

Globalization, while related to the overall economic growth, could also result in increased environmental and occupational hazards. It could influence people's lifestyle worldwide. It reinforces migration from rural areas to cities, which lack the infrastructure to cope with the large influx of inhabitants. As a result, increasing numbers of people could face the problems of inadequate clean water, waste management and housing. Related to this is the fact that people adopt a more hurried lifestyle, which leads to unhealthy habits and an attitude of expecting quick cures, leading to over-prescription of drugs. The

human capital and productivity could be the key to competition in international markets and attracting investment. Good health will increase household income and domestic savings. Therefore, it is important to ensure efficiency and effectiveness of health systems in the provision of key health interventions, such as essential drugs, vaccination and other low-cost preventive measures.

Trade in health services is still minimal in the Region, particularly in comparison with the services traded in other sectors. However, trade in health services would grow with rapid increase in trade liberalization, as well as the increasing use of technological advances. This could facilitate access to a higher level of health care services by the better off, which may also divert human resources from public to more profitable services. This could lead to restricting public staffing levels and lowering of staff quality. Cross-border telecommunications offer potential benefits although their impact is restricted by the limited internet-connectivity in most developing countries.

There are several aspects of globalization which can make a positive influence on the health of the poor population. It is essential that economic benefits of globalization extends to all countries, especially the least developed ones. The economic benefits of globalization need to be translated into health benefits. Potentially adverse effects of globalization on health, as distinct from economic channels, must be minimized. A number of issues need to be resolved effectively taking full account of their health dimensions. Globalization will have a positive impact only if a country can successfully compete in the global environment. Many developing countries still lack the necessary legal and human capital infrastructure to do that, and many of them also experience negative effects at least in the short term.

There are several ways to improve health within a renewed global environment, which include improvement in prevention and case management of priority diseases, improving the performance of health systems, addressing border constraints and cross border spill-ins and support global public goods. To make globalization work for health, international actions are required to support efforts to integrate populations and countries into the world economy through accelerated debt relief, market access and increased financing for areas that increase human security. There is also a need to ensure changes in international rules and institutional arrangements to reflect the needs of the developing countries. At the national level,

governments should increase investments for health – across all its determinants - promote policy coherence across sectors and incorporate health principles into trade, development and investment policies. They should also participate actively and effectively in international development negotiations to support national health goals and for solutions to global and transitional problems.

In the last half a century, global health development has recorded remarkable achievements, while it has also registered increasing inequalities within and between countries. There is a need to look more at improvement of the average health status as well as the increasing "maldistribution" of the health status. There should be a checklist to help policy-makers assess the health impact of globalization, especially on the poor people, in various aspects including effects on national health markets. WHO will work to expand and share knowledge on the effects of globalization on health and appropriate policy responses, strengthen negotiating capacity to place public health interests higher on trade, investment and development agendas and support the control of public health and production and access to public health goods.

2.2 Multilateral Trade Agreements and Health

The views of the World Trade Organization (WTO) on the impact of multilateral trade agreements on health were presented. Trade can be seen as an instrument among many to improve public welfare. The underlining assumption is that trade can improve the climate for investment, production and employment generation, and therefore contributes to economic growth and development. Health is also noted as a prerequisite for economic activities. There are three areas where WTO and WHO can collaborate in carrying out their mandated tasks, namely trade in goods, trade in health services and intellectual property rights.

(a) Trade in goods

All countries have the right to prevent trade for products that pose risks to health. There are WTO rules governing technical barriers to trade which are applied for reasons of protection of human health. Either the Agreement on Technical Barriers to Trade (TBT) or the Agreement on the Application of

Sanitary and Phytosanitary Measures (SPS) covers such measures. However, under these agreements, health is considered a legitimate objective of safeguarding human health. Typically, concerns arise if a measure is discriminatory in nature, or is more trade distorting than necessary to achieve the stated objective for safeguarding health. Therefore, WTO agreements strongly encourage countries to use international standards adopted by international standard-setting process fully involved by all the countries. At the initial stage of the Uruguay Round, the food safety issue was part of the negotiations on agriculture. However, growing concerns over the misuse of food standards as the effective tool for protection in trade led to separate negotiations and thus the SPS agreement was negotiated. The SPS agreement specifically refers to the use of standards, guidelines, and recommendations of the FAO/WHO Codex Alimentarius Commission (Codex) in food trade. WHO plays a key role within the Codex by contributing scientific inputs for standard-setting processes. Another area that needs consideration is the relationship between SPS and International Health Regulation (IHR) of WHO. At its June 2000 meeting of the SPS Committee, the WHO Secretariat presented a paper on the work being done on the revision of IHR currently undertaken under the WHO auspices. There is some relevance with WTO as the proposed revision of IHR implied that WHO could issue binding directives to its Member Countries in order to contain an "urgent international public health event". Such binding directives would have the potential of affecting trade in goods, and possibly also trade in services. The TBT Agreement also encourages the use of international standards on packaging, marking, labelling requirements and conformity assessment procedures, but does not specifically identify a relevant standard-setting organization. It tries to prevent trade from health risks and deals with measures for importing live animals, meat and meat products.

(b) Trade in services

Trade in health services may particularly affect the availability of health services. It is argued that as people move and work with greater ease across borders, there could be increased brain drain from the developing countries to more lucrative destinations in the developed world. Moreover, foreign commercial presence in the developing countries could similarly siphon off trained staff from public facilities to the highly paid private hospitals and practices. These factors may lead to lesser availability of essential health services for those that need them most. However, WTO rules do not prevent

governments from addressing these problems through their domestic policy and regulation. For instance, a government could require a private health service supplier to provide a certain percentage of hospital beds and basic health services free of charge or at reduced prices. In the training of doctors or nurses, governments could even impose stricter requirements on foreign suppliers than on domestic suppliers, but would need to specify these as limitations in the schedule of commitments under the General Agreement on Trade in Services (GATS), in case it had undertaken a market opening commitment in the health service. GATS, along with the WTO Agreement on Agriculture, is in a mandated built-in agenda for the next negotiation. It should also be kept in mind that GATS does not apply to services supplied in the exercise of government authority, i.e. a service that is supplied neither on a commercial basis nor in competition with one or more service suppliers. This is particularly relevant to the health sector.

(c) Intellectual Property Rights (IPRs)

For public health, the key issue is how the enforcement of patent rights on pharmaceuticals affects the availability of drugs, particularly in low-income countries. The challenge is of balancing the high costs associated with research and development (R&D) with the need for affordable access. Access to drugs is a genuine public welfare concern in many developing countries. At the national level, governments may wish to further explore various policy options that could effectively strike a balance between protecting intellectual property rights and addressing broader public welfare concerns. Countries may feed their concerns regarding the review of implementing TRIPS Agreement into the ongoing discussions at the WTO-TRIPS Council.

In the ensuing discussion, the meeting raised a number of specific issues in broad health perspectives. These included, among others: (a) access to essential drugs and vaccines including different pricing for new drugs and vaccines for HIV/AIDS, malaria and tuberculosis; (b) role of the private sector in the financing and delivery and different requirements for foreign firms, (c) exporting health services and health care professionals, (d) health insurance coverage policies, (e) licensing requirement for health professionals, (f) restricting movement of goods and people for infectious disease prevention under IHR, (g) testing the safety of food containing genetically modified material, (h) labelling and advertising restrictions on cigarette and alcohol, (i) banning imports of hazardous substances, (j) access to biotechnology

resources, (k) e-commerce in health products, services and knowledge, and (l) use of traditional medicines or knowledge.

Health issues may also arise from not only the global multilateral trade agreements, but also from regional and bilateral agreements. These issues may not only be solved through multilateral and bilateral trade negotiations, but also through non-trade solutions outside the scope of the trade agreements. In order to solve these issues, there is a need to adopt a *unified national policy,* reflecting the balance of health and trade interests, for international and regional trade negotiations within the framework of WTO, ASEAN, SAARC, AFTA and other international and regional negotiations on health-related subjects, such as WHO Framework Convention for Tobacco Control (FCTC), International Health Regulation, etc.

The national policy should be based on a sound analysis of options and trade-off. There is also a need to promote coherence between national health policy with that of trade policy, through sectoral cooperation, especially between ministries of health, foreign relations, trade and commerce, in the areas of information sharing, provision of solid evidence of health effects, concrete suggestions for change in specific areas of trade policy, joint monitoring and evaluation of health effects of TRIPS and GATS, especially in regard to the process of implementing international agreements. Continuous dialogues with trade, commerce, foreign relations, health and other social sectors are important to make appropriate legal and political frameworks for each country to adopt its own actions to mitigate any serious impact of trade liberalization and globalization.

At the international level, coherence in international health and trade policies should be promoted. For this purpose, studies on the impact of trade agreements on health or health system should be supported. Appropriate working groups and seminars/conferences/training workshops should be convened to address health and trade issues, and WHO should be given more opportunities to participate in WTO's negotiation mechanisms.

2.3 TRIPS Agreement and Access to Drugs

The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) is the most comprehensive international instrument governing all types

of intellectual property rights (IPRs). Since its adoption in 1994, it had generated a lot of discussions and concerns at global, regional and country levels with regard to its potential impact on public health. Concerns are raised basically in regard to the introduction of product patent system, treatment of import at par with domestic production, providing a long patent term of 20 years, inadequate compulsory licensing system, R&D during the patent term, parallel import during patent term, and reversal of burden of proof.

At present, there are wide differences in pricing drugs and vaccines among countries with and without full implementation of TRIPS provisions. The prices of medicines in a country without adoption of TRIPS provisions are generally cheap. They will now be affected by the TRIPS Agreement. Implications of TRIPS are quite visible in many parts of the world from most of the available information. The impact of the TRIPS Agreement on the overall health status is also evolving in the countries of South-East Asia. In view of the mounting pressure from outside, the Patent Act of Thailand had undergone several changes since 1992 to meet a number of requirements, as stipulated in the provisions of the TRIPS Agreement, including product patent and pipeline protection. The assumption to introduce a new patent system, among others, was that it would increase R&D, attract foreign direct investment, encourage transfer of technology, and thus provide, better access of drugs to population. The main findings after several years of adoption of the TRIPS Agreement were that negligible technology transfer and direct investments have been provided and the expenditure on health care, mainly curative, was rising higher. Before 1989, generic firms did better than originator pharmaceutical firms, but the situation is reversed nowadays. Since the 1992 Patent Act, the share of original drug market increased every year, reaching its peak in 1997. One serious implication from the new rule of patent protection is the increasing prices in patented drugs and decreased accessibility to essential drugs, e.g. antiretroviral drugs. The impact is more serious with regard to access to anti-HIV/AIDS drugs. At present, only 5% of HIV/AIDS patients can have access to antiretroviral therapy and of that only a few received treatment with all three drugs. The price of a standard three-drug antiretroviral therapy is very high (more than US$ 500 per month), while a minimum salary of most HIV/AIDS patients is less than US$ 90 per month.

The meeting strongly recommended that national patent laws and regulations be framed or amended in a manner to subserve public health of the country and to balance the rights and obligations of the patent holders,

while maintaining the requirements of the TRIPS Agreement. To ensure public interests for achieving national health goals and to provide for a pragmatic approach to health care programmes, it is necessary for pharmaceutical industries in the countries of the Region to play their role in the health care sector. For achieving this objective, which can be considered in consonance with the spirit of the TRIPS Agreement, the meeting recommended that the governments of the countries in the Region formulate or revise their national patent legislation after a careful review and full discussion on the TRIPS provisions, especially in the following areas:

- One of the objectives of the Agreement is to provide protection and enforcement of IPRs to contribute to the transfer and dissemination of technology in a manner conducive to social and economic welfare and balance of rights and obligations, and hence the issue is how to provide this objective in the national legislation on patent to minimize any negative impacts on health.
- The principle of the Agreement also permits adoption of measures to protect public health and nutrition, as well as public interests in the sectors of vital importance to socioeconomic and technological development. Therefore, national legislation may provide provisions by ensuring public health and nutrition and liberal use of the strengthened role of domestic industries, which are vital sectors for health care.
- The Agreement also permits taking measures to prevent the abuse of IPRs, and restrain trade and international transfer of technology. Member Countries in this respect may take measures to prevent abuse such as continuous imports, non-working of patents, restrictions on export and withholding of transfer of technology.
- In the light of the definition of patentability, discoveries, new dosage form, new usage, new off-patent formulations (including combinations) can be excluded from national legislation.
- The conditions for the use of patent without authorization of patent holder are being provided in the Agreement, such as: use by the government or authorized parties in a situation of unsuccessful attempt for licensing by enterprise on reasonable terms and conditions, and national emergencies or extreme urgency or public non-commercial use should be incorporated in an independent

section on national patent legislation since these are extremely important for health.

- Countries may also allow exceptions to use inventions provided in the Agreement for research, teaching purposes, experimental test of improvement, and experiments for seeking regulatory approval for early marketing after the expiry of the patent (Bolar exception system) and non-commercial purpose. In regard to the exhaustion of IPRs, appropriate provision should be made on parallel import in the national legislation for importing medicines at reasonable prices.

The meeting noted the WHO policy perspectives on access to drugs with the recognition that access to health, including drugs, are human rights. Essential drugs are not simply another commodity. The patent for pharmaceuticals should be managed in an impartial way, protecting the interests of the patent-holder and safeguarding basic public health principles. WHO will support measures that will enhance access to essential medicines in a sustainable way. This includes mechanisms to promote competition, such as price information, generic policies, equity pricing for newer essential and life-saving drugs, reduced duties, taxes, mark-ups, application of TRIPS safeguards as appropriate which include compulsory licensing, exceptions to exclusive rights to promote generic competition and extension of the transitional period. WHO recognizes that the TRIPS Agreement does not prohibit parallel imports though some countries may benefit from lower prices in other countries. WHO policy guidance has been provided in this respect through speeches of the Director-General on various occasions as well as (at least 10) publications and briefing papers.

The meeting also discussed the TRIPS Agreement and its relation to traditional medicine and knowledge. Thailand, in addition to its Patent Act, has adopted two national acts, namely "Protection and Promotion of Thai Traditional Medicine Intelligence Act 1999 and "Plant and Plant Varieties Protection Act 1999". A Community Forest Act for preservation of traditional plants is also under development. These acts cover protection of traditional knowledge (individual and national formulation), accessibility, the role of community and stakeholders, conservation, risk of extinction and public funds. Thailand has the experience of one traditional plant "Plao Noy" being exported and near extinction. There are also issues for IPRs in relation to some traditional practices such as "Thai Massage-Nuad Thai".

The Meeting noted the following discussion points that emerged at the Interregional Workshop on Intellectual Property Rights in the context of Traditional Medicine, held in Bangkok, from 6-8 December 2000:

- The IPRs system may not be applicable to traditional knowledge or medicines which are simple and known since no new chemical entities are involved in that procedures, and therefore, no issue of patent process can be raised. Trade mark does not belong to individual healers or universities, and the issue of trade secret will also, therefore, not be applicable, and the costs of obtaining and maintaining patents will be prohibitive.
- In the national context, there may be different objectives for obtaining patent protection, either to obtain monopoly rights or to stop others from monopolizing. There is a dilemma in this respect such as public interest vis-à-vis private interest (individual or company); publish and share vs. keep it secret, get patent protection; desire to share the benefits widely vs. to benefit financially; and ensure access to affordable medicines vs. commercial interests.
- Within and between countries, there is an absence of mechanism for equitable benefit sharing. There is an issue of biopiracy at the international level and lack of sharing with the community at large. There are different interests between owners of traditional knowledge and research institutions (national/foreign), different R&D priorities between industrialized and developing countries - traditional practitioners vs. modern health care providers; individuals or small-scale traditional medicine industries vs. large (foreign) companies; and different needs of developing countries' populations vs. protection of the interests of large (foreign) companies.
- There is also a gap between 'high tech' and 'low tech' countries. The gap is increasing since developing countries fail to advance the development of their knowledge. The interests may result in the widening of the gap in many areas including cultural/conceptual/ philosophical aspects. In industrialized countries, there is an "extravaganza", an alternative choice, but in developing countries, it is a need for affordable medicine and a part of lifestyle.

- Efforts to solve this problem are hampered by the non-existence of institutional mechanisms for collaboration between local/ community and national levels (but also at the national level, by the lack of financial support) and national and international institutions and lack of a common definition for "invention", "discovery", etc. Also, different perceptions and approaches exist on traditional medicines - some see them as opportunity, others as threats.
- Countries should, among others, develop and use all possible systems to protect traditional knowledge and develop national strategy to safeguard continued access and prevent misappropriation by third parties. A mechanism should be developed to protect their biological resources, ensure equitable benefit sharing and encourage technology transfer.

2.4 Agreement on Technical Barriers to Trade (TBT) and Agreement on the Application of Sanitary and Phytosanitary Measures (SPS)

The Agreement on the Application of Sanitary and Phytosanitary Measures (SPS) was derived from the Uruguay Round of negotiations on trade in agriculture, and covers sanitary and phytosanitary measures. Its purpose is to establish a multilateral framework of rules to guide the development and application of such measures in order to minimize their negative effects on trade and encourage the use of harmonized measures based on international standards, guidelines and recommendations. The provisions of the SPS Agreement also deal with food safety "at the border". As WTO did not have the scientific skills, it decided to use Codex standards, which are sponsored and funded by FAO/WHO. If Codex standards are used, then country standards are considered to be in line with the WTO rules. Another aspect of importance in the SPS Agreement is that Members of WTO have the right to take sanitary and phytosanitary measures on the basis of their own standards, when necessary, to protect human, animal or plant life or health, but these standards must ensure that they are not more trade restrictive than necessary to meet their health objectives; are based on scientific principles and are not maintained without sufficient scientific evidence. WHO is closely linked with SPS trade rules, and as food standards change over a period of time, it is a dynamic scientific process. Concerns relating to genetically-modified organisms are not yet clearly covered by SPS. In order to benefit from the

new possibilities through trade liberalization, developing countries will need to demonstrate that their product meet Codex requirements. The development of agricultural export industries in developing countries may be hampered by the absence of food control infrastructure that would ensure the safety of exported food products. WHO can support the efforts of its Member Countries to build their capacity to meet Codex standards, guidelines and recommendations by cooperating in the establishment of national food control mechanisms. In the case of disputes concerning national health standards stricter than the international one, WHO would be well placed to evaluate the scientific evidence required as justification.

With the evolvement of the SPS Agreement under WTO and its relevance to food safety in trade, there would be an issue on conflict and synergy between the International Health Regulation and the SPS Agreement. Overlap between these agreements occurs only in the area of contaminated goods (mainly food) that could affect human health. IHR also addresses restrictions on travellers, which are of little concern to the SPS Agreement. The SPS Agreement allows Members to exceed international standards when it is necessary to protect health as warranted; IHR, on the other hand, has historically set maximum measures that a WHO Member State can take in response to a disease event. There is also the possibility for a Member State of WHO not to comply with the direction of WHO at the time of disease events, by referring to Article 3 of the SPS Agreement. There is, however, also considerable potential for synergy between the two agreements, including recognition of the agreements, reciprocally. At present, WTO does not recognize the WHO decision process in making risk assessments and statements on trade based on public health and WHO directives cannot be referred to in the SPS process. The Agreement on Technical Barriers to Trade (TBT) concerns also with health, as some technical barriers were raised in trade.

2.5 Health Service and the General Agreement on Trade in Services (GATS)

The meeting was of the view that GATS offers flexibility for countries to decide on how much to open their health service markets to international trade, in contrast to the other WTO agreements. Yet, there are fears of further liberalization in health services for international trade. The meeting felt that the government's ability to protect publicly-provided health services

might be restricted, depending on how the exemption for services "supplied in the exercise of government authority" was interpreted.

On the other hand, countries may favourably consider further liberalization, particularly in Mode 4 - Temporary Movement of Labour. India and African countries recently submitted papers to WTO urging removal of artificial barriers to this form of service trade. It was stated that there was much potential to expand health service trade in this mode, given the large, well-trained pool of health professionals in India, who are already going to work in the UK, Middle Eastern countries and the USA. Despite such movements of health practitioners, they continue to experience discrimination and lack of recognition for their qualifications. To some extent, this may be fostered by the lack of uniform national medical licensing examinations, which should be instituted. WHO might help to smoothen the way for greater movement of health professionals by establishing an international medical qualification examination that would be recognized in all countries. India is now in the process of identifying which countries they might ask for commitments to remove barriers to the movement of temporary labour, including health professionals.

It was also mentioned at the meeting that the interest in promoting "health tourism" using indigenous medical practices such as Ayurvedic Care under Mode 2 - Movement of Health Consumers is growing. Except India, however, no other country in the Region has made commitments in health services under GATS, and thus, there is very little experience to examine. India made commitment under Mode 3 - Commercial Presence, with up to 51% foreign equity allowed, consistent with other service commitments.

There were also some concerns about too many foreign private investors setting up private hospitals; it will exacerbate the problem of undersupply of hospital beds to serve the poor. Since the GATS commitment became effective, the number of foreign investors in private and private-public joint ventures for hospitals has increased, but the broader implications for the health system have yet to be determined. There was a general consensus that if a country opens up a health market sub-sector under GATS, it is essential to prevent potential adverse effects, such as possible "cream-scheming", serving only rich people who can pay for services.

As the actual effects of liberalization of the health sector are largely unknown, some believed that countries should not make any commitments for health services until the effects can be better predicted. Countries may be able to "test the waters" with unilateral market opening, but it can be argued that this does not give any guarantees for foreign investors.

There was some discussion about the interaction between market opening in health services and market opening in health insurance, which comes under the financial sector in GATS sectoral classification. The entry of private insurance companies into developing country markets, while still quite small, could potentially have a large impact on the health system, by creating more demand for expensive health services provided in the private sector. Some argued that this may have no significant negative impact if such trends serve to free up resources in the public sector for the poor. However, it is important to estimate the net effects of such policies - such benefits may be offset by the loss of health personnel from public sector facilities who could be lured by the higher salaries and better working conditions in private facilities. For the health service trade, it is also very important to share information across countries about multinational hospitals or health insurance companies and, therefore, efforts should be made to pool information and make it available to all countries.

2.6 Putting Public Health Interests on the Trade Agenda

Globalization is a fact of life, but its fragility should not be underestimated. The spread of markets outpaces the ability of societies and their political systems to adjust to them, let alone to guide the course they take. This is the challenge faced by most countries of the Region. Experiences show that there would be some conflicts between commercial and health interests and between health and other sectors in the process of globalization, especially in the implementation of the multilateral trade agreements. There are some conflicts of trade and health issues in understanding and practical applications of trade agreements due partly to many ambiguities in the provisions of WTO agreements since writers of the agreements and negotiators were not able to foresee future implications at the times of Uruguay Round negotiations.

The meeting proposed that *public health interests* should be placed on the national and international trade negotiations in future as well, with clear strategies to reduce the impact, and felt that national and regional actions, and collaborative work at the international level are highly important in this respect. National and international strategies need to be developed and adopted for more evidence-based information, public debates and making, revising and adapting national laws and regulations with full consideration of ensuring the health interests, in the new international forum. In this respect, actions are required for national and regional capacity building such as capabilities of national institutions; establishment of national and regional networking; strengthening of national coordination; support for research and development; and public debates. At the global level, collaborative works should be initiated and enhanced to make information for public awareness, research and case studies, tool kits, and short and long term training courses/workshops.

2.7 Utility of Global Public Goods for Health in the Research on the Impact of Globalization

Public goods are recognized as having benefits that cannot easily be confined to a single buyer. Yet, once it is provided, many can enjoy them. Health is best seen as a private good, but one which both produces and is to a significant extent produced by externalities. Externality is an effect of a transaction on someone who plays no part in the transaction itself. The direct externalities of health status are considerable. They include inter-generation effects, the incidence of infectious diseases, reduced pressure on health services and economic effects. Infrastructure system, policy and regulatory regimes and knowledge and technologies are three types of public goods influencing health.

Global public good (GPG) is defined as having non-excludable, non-trivial benefits that cut across borders, generations and populations. The global public goods (GPGs) approach for health should be encouraged and utilized in an increasingly globalization world. The concept of global public goods in respect to health and the approaches to be applied were presented and discussed at the meeting with the purpose of identifying potential GPGs of particular importance to poor people in the developing countries and to

outline how they can be provided and financed to gauge their economic merits and political feasibility.

Possible health-related GPGs are those with cross-border influences on health such as cross-border transmission of infection, health-related behaviour, risk factors and health services. Therefore, it was suggested that case studies should consider the potential cross-border effects of each potential GPG in each of the above appropriate area. The global public goods for health can be identified in terms of types of problem that they address and the types of solution which they offer. Problems conducive to GPG-type solutions can be broadly divided into those which address in-country health problems with cross-country externalities and those which address cross-border transmission of factors influencing health risks (food safety, tobacco marketing, international trade in narcotics, etc.). GPG-type solutions include those in the areas of global governance and knowledge interventions. Case studies need to identify potential GPGs in their respective areas and assess the extent to which they are public in consumption, public in benefit and public in provision.

Case studies should also assess of the potential health and economic benefits of each GPG, including some indication of their geography in two main areas - health effects and economic effects: effects on quality of life of episodes of illness or disability; the effect of premature mortality; financial and non-financial costs of treatment; and other economic costs of ill-health to the individual concerned.

Most GPGs require resources for their production. They may also impose financial or non-financial costs on third parties. In some cases, where poorer households are affected, these costs may have adverse health impacts. Therefore, options for financing GPGs should be considered taking into account the coordinated contribution, earmarked taxes, market-basis mechanisms, etc. Case studies should also address political dimensions such as adoption of international decision to produce GPGs, enactment of legislation and creation of national mechanisms to provide GPGs and enforcement of the legislation, role of stakeholders - government, companies, NGOs and people. In the ensuing discussion, some issues were raised with regard to the ambiguity of the term of “public goods”, real concept of GPGs, its utility and its coverage.

2.8 Tool Kits for Research

The meeting considered the possible tool kits that could be used for researches on the impact of globalization and trade on health. In this respect, the meeting identified and discussed a number of policy issues, research agendas, and training needs in the context of openness, cross-border flows and international institutions, which were the main components of globalization as agreed in the previous session. The following research issues were proposed:

Policy issues:

The following policy issues need to be considered in policy research studies: who wins and who loses; the impact on specific population groups; sequencing; transitional period; growth realities; effectiveness of implementation; safeguard measures; resource allocation; national capacity; nature of cross-border flows and factors influencing the flows; internal potentials and weakness; harmonizing national standards; influence on security and stability; price; technology transfer; R&D, etc.

Research agendas:

(a) **In the context of openness and cross-border flows**, the following research agendas may be considered: setting of indicators; review of implications in the related areas/annotated bibliography; dimension in the transfer of technology and related problems; health information and laws; overall quantitative and qualitative indicators on commercial presence and health production; financial structure and system; sustainability at the national level of production units that provide goods and services; ethical impact of openness; risk factors; effective measures to control the spread of diseases; overall situation analysis; political mapping; trends over times; externality profile; magnitude and direction of flows; benefit for national interests; safety measures at borders; stability of capital flows; disintegrated/proxy data; gaps in areas for further negotiations, etc.

(b) **Areas relating to TRIPS Agreement -** In the areas relating to the TRIPS Agreement, agendas may include issues such as effects of price on drugs; thrust on process technology; impact on R&D; competitive environment; transfer of technology including compulsory licensing;

impact on the implementation of CBD; incentives by governmental and international organizations; and impact on generic drugs.

(c) Research Agendas for GATS - The role of educational institutions in complying with international standards; trade on human resources; impact on domestic and export markets; laboratory capacity; two-tier system; access to health care and quality of services; efficiency measures; improvement of competitiveness; selective cost-effectiveness; contribution to economic growth could also be included in the research agendas for GATS;

Training:

The meeting recommended the initiation of international, regional and country training courses/workshops on public health implications of multilateral trade agreements of WTO to educate the public health community. The proposed *WHO/WTO one-week international short course, to be organized in Geneva in September 2001* would cater not only to professional public health communities in the developing countries, but also to appropriate WHO staff, trade and commerce advisers and officials, and interested NGOs. Similar regional and sub-regional workshops/training courses with a modified programme/design course for senior policy-makers and managers of ongoing programmes could be considered, and organized at the College of Public Health, Chulalongkorn University, Thailand and elsewhere.

2.9 Setting for Action - Country Priorities

There are no universal formulae for liberalization, and impacts of globalization and trade on health differ from country to country depending on the extent the individual countries are involved in, thus requiring different priorities for action. Therefore, after plenary deliberations, the meeting divided itself into four groups comprising experts from a country and international experts, to identify the country's specific priority actions, mostly in two areas - research and training activities.

In general, the meeting agreed on the initiation/undertaking of the following activities as priority in the respective countries (India, Indonesia, Sri Lanka and Thailand) based on specific circumstances and research capability.

WHO will work closely in developing and implementing such research studies, with appropriate national institutions.

- Mapping of globalization, trade and public health;
- Study of the characteristics and impact of commercial presence on the hospital sub-sector;
- Study of the characteristics and impact of the movement of health personnel on the economy and the health status;
- Case study on the impact of trade liberalization on import/export of traditional medicine and traditional knowledge;
- Case study on national legislation on protection and promotion of traditional medicine and knowledge;
- National workshops/seminars on the impact of cross-border flows/spill-over effects and GATS on health services, and
- ASEAN workshops of the impact of trade on health services.

3. CONCLUSIONS

The meeting arrived at the following conclusions:

(1) There is a vast amount of country experiences on the impact of globalization on health, including those related to multilateral trade agreements.

(2) While some countries are undertaking policy actions to address issues of national capacity building, many others need concerted action to strengthen their national capacity.

(3) All WTO members (both full members and observers) in the Region need to establish or strengthen existing national coordinating mechanism(s) for appropriate harmonization of work between sectors.

(4) National centres of excellence, which will specifically deal with research and training on multilateral trade agreements, should be identified and their collaborative activities further supported.

(5) Networks of these institutions at both national and regional levels should be promoted. Such networks should function as scientific and political forums as well as pools of regional experts. They should also be involved in the monitoring of implementation and impacts of multilateral trade agreements, and hare and provide evidence-based information to other regional countries, and to other parts of the world.

(6) A number of research studies, including country case studies with practical examples, are required for countries to adopt and adapt.

(7) Senior and middle-level administrators in the health, trade and legislative sectors need to be trained or orientated on international development and implications of multilateral trade agreements on domestic policies as well as on health, trade and other social areas.

(8) Public debates need to be organized and information disseminated.

4. RECOMMENDATIONS

(1) WHO, together with WTO and other UN Agencies, especially UNDP, UNCTAD, UNICEF and WIPO, should organize a series of national, regional and global activities aimed at strengthening national capacities to implement multilateral trade agreements in ways that will promote and protect public health.

(2) WHO should facilitate and provide technical assistance to the work of public health experts, groups or special committees/task forces, established in the countries or at the regional level, who will be responsible for the review and formulation of national and regional policies, related to globalization, trade and health.

(3) International agencies (UN and others) should organize forums and dialogues and also support appropriate country-specific or cross-country research studies in order to elucidate evidence-based information for policy for addressing globalization, trade and international health.

(4) Countries should initiate national and international training programmes to strengthen appropriate human resources to analyse the effects of globalization on health.

Annex 1

PROGRAMME

Tuesday, 12 December 2000

0830-0900 hrs.	Registration
0900-0930 hrs.	Inaugural Session Address by Dr Uton Muchtar Rafei, Regional Director, WHO/SEARO
1000-1200 hrs.	Globalization and health: Panel Discussion (Dr Nick Drager; Professor Ranjit Roy Chaudhury; Professor Wattana S. Janjaroen and Mr Tejendra Khanna)
1300-1430 hrs.	Overview of multilateral trade agreements - Presentations by Erik Wikjstrom (WTO) Debra Lipson (WHO/HQ)
	Discussion
1500-1700 hrs.	Access to drugs, indigenous knowledge and TRIPS: Presentations on: • TRIPS agreement by Mr B.K. Keayla (India) • Country experiences: – Dr Ashwani Kumar (India) – Prof Siripen Supakankunt and Ms Yuwadee Patanawong (Thailand)
	Discussion

Wednesday, 13 December 2000

0900-1030 hrs	Risk to health - Communicable and non-communicable diseases and health-related trade agreements (SPS and TBT) • Presentation on SPS/TBT/IHR by Mr Erik Wikjstrom (WTO) • Joint presentation on country experience: Mrs K. Fernando and Dr Nisha Arunatilake (Sri Lanka)
	Discussion
1100-1230 hrs.	Health services and GATS: Panel discussion
	(Professor Wattana, Chulalongkorn University (Thailand);

	Mr Ravi Kanth; Mr SrinivasTata (India); and Prof Dr Achmad Djoyosugito (Indonesia)
1330-1500 hrs.	Putting public health interests on the trade agenda: Presentation by Dr Than Sein, WHO-SEARO – Issues and strategies, – Joint research, network development, – Development of common positions for trade talks, etc. Discussion
1530-1700 hrs.	Global public goods for health - Presentation by David Woodward, WHO/HQ Discussion

Thursday, 14 December 2000

0900-1000 hrs.	Developing a training programme for national officials on trade and health Presentation by Dr Robert Beaglehole (WHO/HQ) supplemented by HSD-Globalization Team, WHO/HQ Discussions
1030-1230 hrs.	Globalization and health: Country tool kit for analysis – Presentation by WHO/HQ-Globalization Team, followed by discussion on: – specific data collection and regular collection of indicators, – methods for conducting impact assessments on health risks, health system, etc. – new frameworks and tools for analysis, etc.
1330-1500 hrs.	Setting priorities for action – Country, regional and global level – Advocacy, research, training, analytic tools, etc.
1500-1530 hrs	Summary/Next Steps/ Closing Session

Annex 2

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