

# Unit 5 Globalisation and health

## OBJECTIVES

- 1) To understand how globalisation affects the determinants of health.
- 2) To understand the implications for health policy of international agreements relating to trade.
- 3) To show how experience in the field of health in developing countries has influenced health work in the UK.

## Method

This is a large unit. For seminar teaching, it can perhaps be divided into two sub-units: one on the implications of globalisation for health; and the other on the implications of the World Trade Organisation for health policy. Questions on both areas follow at the end. The whole unit can be used as a starting point for a special study module. A final part of the unit is devoted to sharing knowledge between developing and developed countries – a nicer aspect of “globalisation”!

## Warning!

Globalisation means different things to different people, and there are many different interpretations of its impact on health. This unit puts forward a number of opinions about globalisation which would possibly clash with the views of governments and international agencies such as the International Monetary Fund and World Trade Organisation (WTO), as well as of pharmaceutical companies and other private sector corporations. Examine the evidence for yourself (a range of sources where different views can be found are listed at end of this unit).

## Introduction

Rarely heard of before the mid-1980s, “globalisation” is now a media buzzword and a driver of political action on every continent. Its economic, social and political implications are widely discussed.

From an economic perspective, **globalisation can be defined as a process of movement whereby the obstacles to trade and movements of people *between* countries are progressively reduced so that they are no greater than the obstacles *within* countries.** The factors which prevent this process from occurring include natural barriers such as transport and communication costs, and artificial barriers such as tariffs, quotas and exchange controls.



Selling Avon cosmetics, Amazon, Tapajos river

More broadly, the term globalisation is also used to refer to a whole series of cultural and political shifts including the increase in the speed and geographical reach of media and communications technologies; a decrease in power held by national governments and a corresponding increase in the influence of “supra-national” entities such as transnational corporations (TNCs); rapid urbanisation, migration and international travel; and the spread of consumerist and materialist values. The health policy specialist Kelly Lee has drawn up a list of the fundamental questions some of these shifts pose for health (box 5.1).

This unit comments on some of the health implications of the primary drivers of the contemporary globalisation process, namely financial and trade liberalisation, and the globalisation of production through Foreign Direct Investment (FDI). It also looks at the implications of agreements made at the World Trade Organisation for health policy.

**BOX 5.1****Globalisation – Questions for health**

**How has globalisation affected the epidemiology of disease within and across countries? Which diseases are most affected? What populations are most affected? What are the implications for strategies for prevention, control and treatment of disease? What are the implications for International Health Regulations?**

**Global migration and mobility of people**

**How is the spread and control of infectious disease affected by increased movement of people across national boundaries? What are the health needs of globally migrant labour, (un)documented migrants, displaced people?**

**Global financing of health care**

**How will national governments pay for health care within a globalised economy of mobile labour and capital? Can a global tax base exist? How has the globalisation of finance influenced health financing? What global trends exist in health-sector aid?**

**Global trade and production**

**How should global trade and production be regulated to protect human health against infectious disease, industrial hazards, product safety, export of hazardous waste etc.? Can occupational health and safety standards be adopted globally? What are the implications for regional free-trade agreements for health care?**

**Global information and telecommunications**

**What impact are global communications having on the provision of health services? What implications are raised by global inequities of access to such technologies? Are health needs represented in technological development? How can global communications be used more effectively to address health needs?**

**Global civil society and governance**

**Who are the key agents and are they changing (e.g. non-governmental organisations (NGOs), private sector)? To what extent is pluralism emerging in global health policy? Are existing international health organisations, notably the UN, adequate to represent the complexity of emerging interests? How can global power and global responsibility be balanced? What institutional mechanisms are needed to facilitate the global policy process?**

**Global health law and legal system**

**Do international health regulations need to have “more teeth” to deal with global health issues? How can accreditation of health care facilities and licensing and certification of health professionals be maintained in a globalised context? What issues of intellectual property rights (e.g. pharmaceuticals, medical technology and knowledge) need to be addressed?**

*Source: Kelly Lee. Shaping the future of global health co-operation: where do we go from here? Lancet 1998; 351: 899-902*

## EVIDENCE OF ECONOMIC GLOBALISATION

Evidence that globalisation is occurring is generally based on measurements of the extent of global trade and the mobility of capital. For example, it has been noted that:

- World exports of goods and services almost tripled between the 1970s and 1997 in real terms;
- Levels of FDI have increased substantially, from \$50 billion in the first half of the 1980s to \$318 billion in 1995;
- Annual trade in services grew by an average of 12% annually between 1970 and 1990;
- Cross-border transactions in financial assets in Japan, the United States and Germany rose from less than 10% of GDP in 1980 to 80%, 135% and 170% respectively in 1993;
- Daily turnover in the world's foreign exchange markets increased from around \$1 billion in the mid-1970s to \$1 trillion in 1996;
- There have been huge declines in transport and communication costs: shipping costs fell by two-thirds between 1920 and 1990. The operating costs of the world's airlines fell by 60% between 1960 and 1990. Between 1940 and 1970, the cost of an international telephone call fell by more than 80% and between 1970 and 1990 by 90%. In the 1980s, telecommunications traffic was expanding by 20% a year.

### Is globalisation really happening?

Nevertheless, some commentators have argued that such trends are not new, and that their effects are relatively limited. They suggest that the world economy was just as integrated before the First World War as it is now. For example, comparing the share of exports in Gross Domestic Product – for 17 industrial countries for which figures are available – shows that it was only a little higher in 1993 (14.5%) than in 1913 (when it was 12.9%). They point out that foreign direct investment flows for the large part between Japan, Europe and North America. Only a few mostly richer developing countries (mainly in East Asia and Latin America) have received substantial amounts of FDI. Critics of the globalisation thesis also highlight the fact that the mobility of labour internationally is substantially less than in previous eras.

However, this type of criticism does not negate the fact that there has been an increase in the size of capital flows and trade during the last two decades of the twentieth century; that their geographical scope is increasing: and that, due to the communications revolution, markets are able to react to economic changes and world events with greater speed.

**TABLE 5.1**

**Top corporations had sales totalling more than the GDP of many countries in 1997**

Country/Corporation	GDP or total sales (US\$ billions)	Country/Corporation	GDP or total sales (US\$ billions)
<b>General Motors</b> . . . . .	<b>164</b>	<b>Marubeni</b> . . . . .	<b>124</b>
Thailand . . . . .	154	Greece . . . . .	123
Norway . . . . .	153	<b>Sumitomo</b> . . . . .	<b>119</b>
<b>Ford Motor</b> . . . . .	<b>147</b>	<b>Exxon</b> . . . . .	<b>117</b>
<b>Mitsui &amp; Co</b> . . . . .	<b>145</b>	<b>Toyota Motors</b> . . . . .	<b>109</b>
Saudi Arabia . . . . .	140	<b>Wal Mart Stores</b> . . . . .	<b>105</b>
<b>Mitsubishi</b> . . . . .	<b>140</b>	Malaysia . . . . .	98
Poland . . . . .	136	Israel . . . . .	98
<b>Itochu</b> . . . . .	<b>136</b>	Colombia . . . . .	96
South Africa . . . . .	129	Venezuela . . . . .	87
<b>Royal Dutch/Shell Group</b> . . . . .	<b>128</b>	Philippines . . . . .	82

## Globalisation and liberalisation

The process of globalisation in its current phase has been assisted by a parallel process of liberalisation which has gone a considerable way to releasing investment and trade from the controls placed upon them by governments. For example, developed countries have promoted privatisation and deregulation as part of economic reform programmes; key international financial institutions such as the World Bank and International Monetary Fund (IMF) have encouraged liberalisation in poorer countries through conditions attached to their loans; and the World Trade Organisation (WTO) was brought into existence in the mid-1990s to oversee the freeing up of trade in goods and services internationally.

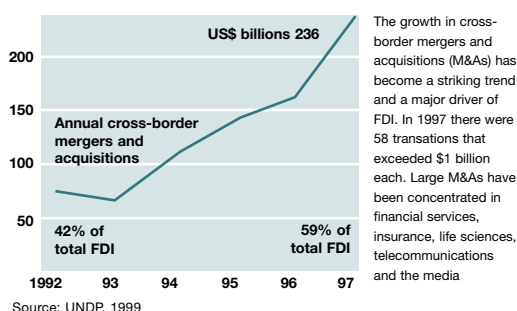
## Globalisation, poverty and inequality

Orthodox economic theory predicts that higher levels of international trade and investment will encourage convergence between national economies. However, at the present time it does not appear that differences in per capita incomes between countries are narrowing. In fact it looks like the gap between richer and poorer countries is actually widening. The United Nations Development Programme (UNDP) has estimated that the ratio of the income of richest 20% of the world's population to the poorest 20% has increased from 30 to 1 in 1960 to 78 to 1 in 1994. The United Nations Conference on Trade and Development (UNCTAD) has noted that between 1965 and 1995 only Southern Europe and East Asia have converged with the developed countries in terms of income; over the same period of time, real GDP per capita in sub-Saharan Africa halved in relative terms and Latin America's has fallen by 30% since 1979. In fact a trend towards income divergence has been a feature of the global economy throughout the twentieth century, and possibly as far back as 1600.

Perhaps even more significantly, there is evidence of increasing income inequalities within both developed and developing countries. The degree of inequality is important for poverty reduction as economic growth will lift far fewer people out of poverty where inequality is deeper. Recent research in the developed world has also shown that within rich nations it is income distribution that determines levels of life expectancy rather than absolute levels of Gross Domestic Product per capita. The more equal a society the healthier (and more socially cohesive) it tends to be.

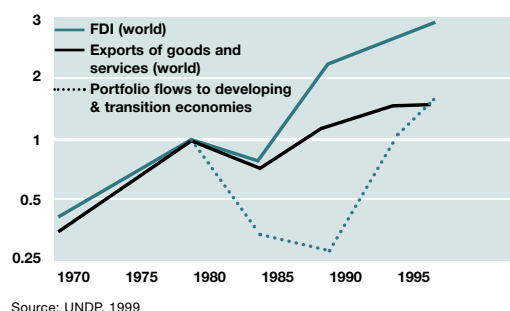
Evidence from dozens of countries indicates rising income inequality during the 1980s and 1990s, in contrast to the general trend towards equalisation over the preceding thirty years. Why might this be?

**FIGURE 5.1** Cross-border mergers and acquisitions



Source: UNDP, 1999

**FIGURE 5.2** Rapid growth in trade and capital flows



Source: UNDP, 1999

The economist Giovanna Andrea Cornia has noted that generalisations are not always possible about inequalities, and that explaining changes in their degree should always mean making reference to the variety of policies implemented at the national and international level. However he argues that several common policy trends, which are intimately linked with the globalisation process, lie behind the increase in income inequalities at the present time. They are described below.

### *IMF and World Bank stabilisation and structural adjustment programmes*

IMF stabilisation programmes (implemented over much of the developing world during the past twenty years) have often produced recessions. In developing countries recessions tend to lead to a worsening of inequality because wages are more downwardly flexible than profits, mainly because of the lack of labour market institutions (such as unions) which can defend them.

Devaluation, measures to “get prices right” and trade liberalisation introduced in particular as part of World Bank structural adjustment programmes have also had varying effects: if trade liberalisation is introduced or currency devaluation occurs in situations of wide agricultural inequality, those who own the most assets tend to gain disproportionately from expanding markets in tradable goods, aggravating income distribution problems. Recent theories concerning the impact of trade liberalisation also predict a rise in inequality after liberalisation because the import of new and better technology raises the demand for skilled labour and diminishes the need for – generally more abundant – unskilled labour.

### *Financial liberalisation*

The widespread deregulation of financial markets has also acted as a driver of inequality. Liberalisation in this area has tended to increase the returns to capital and increase the share of GDP accruing to non-wage incomes. Since 1980 there has been a shift to non-labour incomes in 5 of the G7 countries, with rises of 5% in Italy, Japan and West Germany and 10% in France.

### *Privatisation*

Privatisation may have caused a sharp rise in inequality, as state-owned assets are transferred into the hands of a financial elite. Russia is an obvious example here, but also countries such as Guinea-Bissau and Mozambique where decollectivisation has not benefited the poor who are least able to protect their land rights.

### *Changes in labour market institutions*

Greater wage flexibility, including the erosion of the minimum wage in many countries, less regulation and diminished trade union activity have all contributed to the rise in earnings inequalities which according to Cornia has been seen “almost everywhere”.

### *Diminishing of the re-distributive role of the state*

The global “roll-back” of the state has meant that there has been a tendency towards a lower degree of re-distribution and a higher degree of targeting of public benefits. Unfortunately, a shift from universal subsidies or provision of services towards sharper targeting can mean that vulnerable groups amongst the population stop being covered. The elimination of food subsidies, whose use has been widespread in the developing world and which make up a higher share of the total income of the poor than the non-poor, is known to worsen income distribution.

It is clear that specific policy actions, and not simply technological progress, have played an important role in determining both the extent of the globalisation process and conditioning the impact it makes at the national level. The following sections consider some specific concerns related to the impact on health of trade and financial liberalisation, the two great motors of globalisation.

## The impact of financial liberalisation

At the beginning of the 1990s, some developing economies, mainly in East Asia and Latin America, began to attract new types of flows of finance from the developed world. These differed from the loans to governments which were previously the typical form of development finance. New financial instruments included bonds, foreign direct investment in production capacity (FDI), portfolio equity investment in shares, and inter-bank deposits. There has also been a shift in the destination of the flows from the public to the private sector.

### *Benefits and costs of FDI*

At the global level, orthodox economic theory predicts that the major effect of financial liberalisation will be to prompt a movement of capital from “capital-rich” countries to “capital-poor” (but “opportunity-rich”) ones, leading to higher investment and growth rates in the world economy overall, as well as convergence amongst countries with respect to levels of development. However, as noted earlier, despite widespread liberalisation efforts in the developing world, capital flows are still concentrated mainly in the developed countries; and, as the economist Eatwell comments, at the same time as the size of financial flows has increased exponentially there has also been a “sharp deterioration in economic performance in the G7, the OECD (Organisation for Economic Co-operation and Development) as a whole, and in virtually all developing countries with the exception of some countries in East and South-East Asia” (Eatwell’s paper was written before the Asian crisis of 1997/8).

Proponents of financial liberalisation argue that increased foreign investment can bring a number of benefits to developing countries including extra foreign exchange, increased government

revenues (gained from taxing investors), job creation and the transfer of knowledge and technology. Such rewards could be expected to boost both national treasuries and personal incomes and have multiple beneficial effects for health. However foreign investment may not deliver the expected rewards. For example, investing companies may limit the extent of technology and knowledge transfer by employing expatriate workers or by patenting equipment. Jobs created by foreign investment also have a tendency to be in capital-intensive manufacturing industries, and not in great numbers. Some of the health concerns arising from the activities of transnational corporations (TNCs) are considered in box 5.2.

#### BOX 5.2

#### TNCs and health

**Transnational corporations trading in the health sector have prompted major breakthroughs in pharmaceutical and food technology. However, concerns have been raised about some of their activities, including:**

- **The sale of pharmaceuticals and pesticides banned in the home country of the TNC;**
- **Inadequate labelling of drugs: one study found that two-thirds of 241 pharmaceutical manufactures by US-based TNCs and sold to developing countries had severe labelling deficiencies;**
- **The intensification of the marketing of tobacco in developing countries, as markets narrow for cigarette companies in the developed world.**

*Source: States of Disarray – United Nations Research Institute for Social Development, 1995*

## BOX 5.3

## Health effects and the East Asian financial crisis

The huge outflow of capital from five of East Asia's main economies (South Korea, Thailand, Indonesia, the Philippines and Malaysia) had huge economic and social effects. Workers were sacked and wages fell as companies collapsed; and as currencies were devalued, prices for imported goods rose dramatically. Measuring this type of large-scale change is complicated by the fact that it will have differing impacts on people depending on their pre-crisis situation (in terms of income, wealth, occupation, gender and ethnicity and so on), and that some changes (such as the effects of nutritional decline) will take years to become apparent.

**Effects on incomes and poverty**

In the twenty years preceding the crisis, East Asian countries had seen living standards rise enormously. In 1975 six out of every ten East Asians lived in poverty. By 1995 this figure had fallen to two in every ten. However, the crisis was expected to double the number living under the poverty line in the 5 main crisis economies. Millions lost their jobs in the immediate aftermath; this can often mean total loss of income for individuals, as many of the East Asian countries have few social safety nets such as unemployment benefits. Women tend to bear the brunt of declining household income, and often have to increase the hours they work both inside and outside the household – with serious implications for their own health and the health of their families.

**Effects on prices**

Rice accounts for 30% of household spending for the poorest tenth of the population in Indonesia, but malnutrition threatened as its price tripled between summer 1997 and 1998, because of the massive devaluation of the rupiah, the effects of El Nino which brought drought to the country and stockpiling by poor rice farmers and corrupt officials. The price of imported powdered milk trebled after the onset of the crisis and there were reports of poor families feeding their infants sweetened tea rather than milk.

**Effects on government social expenditures**

When economies collapse all government expenditures face the threat of cuts. In the health sector, this can be compounded by the rise in prices of imported supplies caused by devaluation. Reports from Indonesia at the time (where imports account for 60% or more of the pharmaceuticals used in the country) indicated that prices rose two- or three-fold. The World Bank noted that "this change in relative prices is unlikely to be fully reversed, and will require long-term adjustments in drug consumption patterns."

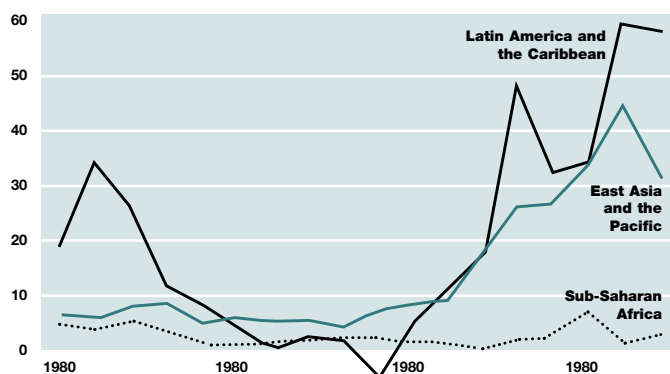
World Bank focus groups in Indonesia and the Philippines also noted that children were not being sent to school as households could no longer afford fees, textbooks and other essential items, or daily costs such as bus fares and food costs.

The economic benefits of FDI also have to be balanced against the costs which countries incur when they try to obtain it. Surveys indicate that investors look for stable macro-economic growth (leading to increased consumer demand), effective legal systems and higher educational levels before they consider investing in countries. This checklist implies a number of things: firstly, that it is the richer developing countries with higher levels of education and better infrastructure which will benefit most (at least in the first instance) from FDI. Where investment occurs in "riskier" low-income countries, investors are likely to demand much higher profit remittances which may increase foreign exchange constraints for poor countries over the medium and long term. This is a particularly important consideration for the health sector which relies heavily on foreign currency to buy the imports it needs to function. Secondly, increasing dependence on FDI flows means that developing countries have to compete for investment and as a result

FIGURE 5.3

**Portfolio flows have brought severe volatility to many markets**

Net intermediate portfolio investment (US\$bn)\*



\* includes bank and trade-related lending

Source: UNDP, 1999.

1990s, much of which was highly liquid and invested in assets such as shares and property, whose values expanded massively. Whilst economies kept on booming, investors were happy to pour more and more money into the region. However, market perceptions changed swiftly during early to mid-1997, as the East Asian economies were suddenly perceived by the markets to be heading for economically difficult times. When the Thai government decided to devalue its currency in August, the outrush of capital from Thailand, and then in a contagion effect, from much of the rest of the region, was huge. A net inflow of capital of \$97 billion in 1996 became an outflow of \$8 billion by the end of 1997, a reversal worth \$105 billion or about 10% of the GDP of the region's main economies. The implications for people's livelihoods were dramatic (Box 5.3 deals with some of the main health effects).

Perhaps the most disturbing element of the Asian crisis is the fact that it was investors' perceptions rather than a dramatic change in the macro-economic fundamentals which caused the crisis. This fact had also been noted in relation to an earlier financial crisis which hit Mexico in 1994, as *The Economist* pointed out at the time:

***"Mexico was one of the third world's stars. It was a practitioner of sound macro-economics (witness its prudent fiscal policy); an ardent liberaliser; and thanks to its membership of the North American Free Trade Agreement (NAFTA), a privileged supplier to the world's biggest consumer-goods market."***

In Thailand the situation was much the same. The development economist David Woodward argues:

***"In both cases, the crisis was brought about by an abrupt change of market sentiment. Nothing changed dramatically in the countries' domestic economies; and the changes in their external economic environment, while unhelpful, were relatively limited. The key change was a shift in the attitude of international financiers from extreme optimism to pessimism, resulting in a sudden change from large inflows of foreign capital to large outflows."***

governments may offer incentives such as tax breaks to investors that will potentially reduce the amount of money in the public purse which can be devoted to health and education. The competitive process may also provoke a lowering of environmental and labour standards.

*Volatility of capital flows*

A further issue arises most notably with regard to other more volatile and liquid flows of capital like portfolio equity investment and inter-bank deposits, which can leave countries quickly if investors panic. As stated earlier, East Asian countries received vast amounts of capital inflows during the first half of the

### Destination of financial flows

The final point to highlight is the shift in destination of financial flows from the public to the private sector. This means that governments have less control over capital flows, and additionally, because developing countries have been pushed into eliminating capital controls, this means that governments have much less power to influence the macro-economic fortunes of their country. However, it is the government or the international financial institutions (who use taxpayers money) who bail-out the private sector when times are tough, as they did during the Asian crisis. In effect the new paradigm of development flows has given benefits to the private sector whilst transferring substantial risks to governments and the public at large.

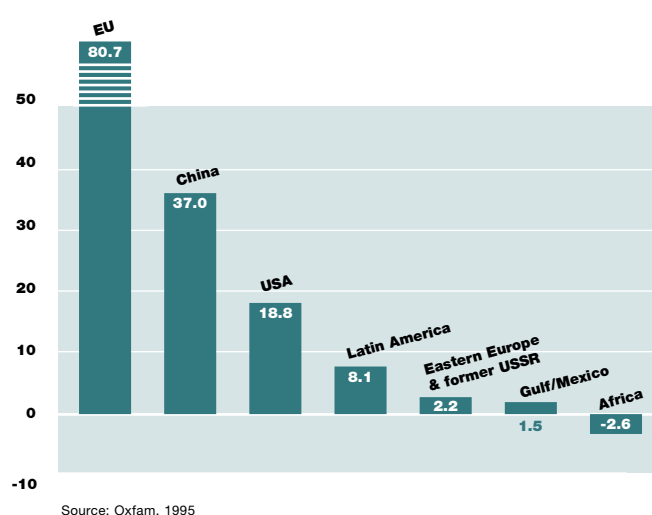
### Impact of trade liberalisation

The movement towards greater trade liberalisation was given impetus by the conclusion of the Uruguay Round of the General Agreement on Tariffs and Trade (GATT), and the setting up of the World Trade Organisation in 1995 (see figure 5.4). Although the negotiations were supposedly about setting a level playing field for world trade, their projected economic outcome tends to favour the developed economies and the larger and/or richer of the developing economies, with the EU gaining an estimated \$80 billion a year from the “improved” trading environment, China nearly \$40 billion and the United States about \$20 billion. Astonishingly the poorest nations stand to lose as a result of the negotiations. Africa is actually expected to lose over \$2 billion per year. Continuing problems for poor countries in the global trading system include:

- The dependence of poorer economies for most of their export revenues on a few primary commodities, whose prices are falling;
- Unfair trading practices on the part of richer nations, including:
  - Continuing high levels of subsidisation leading to low-cost produce being dumped on developing nations, threatening the livelihoods of producers in those countries. In some countries, imports of wheat have displaced local staple foods, changed dietary patterns and increased dependence on foreign sources of food;
  - Slow reduction of tariffs on developing country produce, especially tariffs on processed goods (whose export could earn developing countries more money).

Whilst trade liberalisation could bring important benefits to certain sectors of economies, it can also hold out the threat of swift destruction of livelihoods. Oxfam shows how in the Philippines the proposed removal of quotas which restrict imports from competing in local corn markets could have massive implications. Eighty percent of corn farmers live below the poverty line in the Philippines, and their situation is exacerbated by entrenched inequality in the agricultural sector which manifests itself in unequal access to land and other productive assets. Oxfam estimates that opening the corn sector to cheap American imports, whose price corn

**FIGURE 5.4** GATT winners and losers  
(projections to year 2002)



farmers would not be able to beat, would lead to a loss of livelihood for half-a-million households. It is sobering to note that in the United States on average \$29,000 is given to every farmer in subsidies, whilst in the Philippines, the average annual income of a corn farmer is about \$300. “Free trade” between countries does not necessarily take place on a level playing field.

## Mobility of labour

A final aspect of globalisation which is very characteristic of previous periods of international integration is labour mobility. Rapid economic change tends to stimulate large-scale migration within and between countries, as households seek new opportunities to maintain or expand their incomes. The large-scale migration which took place from Europe to the United States in the nineteenth century was prompted by a labour surplus in agriculture in European countries brought about by the industrial revolution; the United States was also undergoing an industrial revolution but had a shortage of labour – as a result millions crossed the Atlantic in the half century before the first World War. Much of the convergence of incomes between countries from 1870-1913 can be attributed to the high mobility of labour during that period of time.

Today, although travel is quicker there are many barriers to such a high level of mobility occurring again, most notably the immigration controls imposed by developed nations. Nevertheless there are significant levels of cross-border migration – for example the millions of people who have left South and South-East Asia to work in the Gulf States. The remittances they send home are an important benefit to their economies and the income of individual households. However, there needs to be more research on the physical and mental well-being of migrants and the households they leave behind, before health implications can be properly assessed.

A major trend to note with regard to the health impact of labour migration is the “skills-drain” resulting from the outflow of health-sector workers from developing to more developed nations. This is a substantial problem for poorer countries, the viability of their health services and ultimately the health of their populations, and is a process which compounds global inequalities even further. According to Oxfam, there is one Indian doctor working in the US for every 1,325 American citizens, while in India there is one doctor for every 2,400 people. Almost two-thirds of the Ghanaian doctors trained inside the country in the 1980s are now working overseas.

**TABLE 5.2 Views from the UN and the World Bank**

<b>View from the UN</b>	<b>View from the World Bank</b>
<p><b>On globalisation</b> Increased global competition does not automatically bring faster growth and development</p>	<p><b>On globalisation</b> There is a positive link between freeing markets and trade and eradication of poverty in the long term</p>
<p><b>On impact of trade on wages for unskilled workers</b> In almost all developing countries that have undertaken rapid trade liberalisation, unemployment has increased and wages have fallen for unskilled workers</p>	<p><b>On impact of trade on wages for unskilled workers</b> There is no evidence to justify fears that free trade pushes down wages for unskilled workers in developing countries</p>
<p><b>On world growth</b> Growth of the world economy this year will again be too slow to make a significant dent on poverty</p>	<p><b>On world growth</b> The prospects for the global economy are the most promising for many decades for growth and for poverty reduction in the developing countries</p>
<p><i>Trade and Development Report 1997, UNCTAD</i></p>	<p><i>Global Economic Prospects 1997, World Bank</i></p>
<p>From: Allen and Thomas, <i>Poverty and Development into the 21st Century</i>. Oxford University Press, 2000. Source: Denny, C. “Rich-poor divide could cause popular backlash”, <i>The Guardian</i>, 16 September 1998.</p>	

## WORLD TRADE ORGANISATION: IMPLICATIONS FOR HEALTH POLICY

### Overview

The World Trade Organisation is set to become one of the most important influences on international health today. This part of the unit examines three areas where its impact on health policy is being felt.

- Public health regulations and international standard-setting
- The implications of tighter intellectual property rights
- The increasing potential for trade in health services, and how this may affect the structures of health systems and how they are financed.

### Introduction

As part of the globalisation process, world trade is growing substantially. In fact, the share of trade in global GDP has almost doubled to 42% over the last three decades. This growth is projected to continue, boosted by the establishment in 1995 of the World Trade Organisation, an international body which oversees the global trading environment. The WTO has the power to enforce nations to tear down trade barriers and end discriminatory policies aimed at other exporting nations (see box 5.5). At the end of November 1999 the WTO's latest Ministerial Conference convened in Seattle, USA, to discuss further changes to the rules of world trade. The talks collapsed in a blaze of publicity, bogged down by rifts between the two main power blocks – the European Union and the United States – between developed and developing countries and by the impact of the vast protests by environmental, labour and human rights activists. Nevertheless, previous successful rounds of negotiations mean that the WTO already has large implications for health and health policies.

### Implications

Broad public health concerns are deemed to have been dealt with in two places in the General Agreement on Tariffs and Trade (GATT) which forms the basis for WTO action. These are Article 20 of the GATT and its consequent elaboration in the Agreement on the Application of Sanitary and Phytosanitary Measures (SPS) (see box 5.6).

#### BOX 5.5

#### The World Trade Organisation

**The WTO came into operation on 1 January 1995 and is the legal and institutional foundation of the multilateral trading systems. Based in Geneva the WTO provides the principle contractual obligations determining how governments frame and implement domestic trade legislation and regulations. It is the platform on which trade relations among countries evolve through collective debate, negotiation and adjudication.**

**The essential functions of the WTO are:**

- **Administering and implementing the multilateral and plurilateral trade agreements which together make up the WTO;**
- **Acting as a forum for multilateral trade negotiations;**
- **Seeking to resolve trade disputes;**
- **Overseeing national trade policies; and**
- **Co-operating with other international institutions involved in global economic policy-making**

**By the end of 1999 there were 135 country members of the organisation. The WTO is headed by a Ministerial Conference, which meets at least every two years and can decide on all matters under any of the multilateral trade agreements. Between meetings, day-to-day operations, notably dispute settlement procedures and trade policy review are overseen chiefly by the General Council, together with a number of subsidiary entities. All Members of the WTO belong to these bodies, in which decisions are generally reached by consensus; when this is not possible, decisions are taken by a majority vote, on the basis of “one member, one vote”.**

## BOX 5.6

**The health related exceptions in Article 20 of the General Exception in the General Agreement on Tarrifs and Trade; and the elaboration regarding the application of sanitary and phytosanitary measures as set out in the Agreement on the Application of Sanitary or Phytosanitary Measures**

**Article 20 of GATT**

Subject to the requirement that such measures are not applied in a manner which would constitute a means of arbitrary or unjustifiable discrimination between countries where the same conditions prevail, or a disguised restriction on international trade, nothing in this Agreement shall be construed to prevent the adoption or enforcement by any contracting party of measures:

- a) necessary to protect public morals
- b) necessary to protect human, animal or plant life or health
- ...
- e) relating to the products of prison labour;

**Agreement on the Application of Sanitary and Phytosanitary Measures:**

1.1. This Agreement applies to all sanitary and phytosanitary measures which may, directly or indirectly, affect international trade. Such measures shall be developed and applied in accordance with the provisions of this Agreement.

**2. Basic rights and obligations:**

2.1. Members have the right to take sanitary and phytosanitary measures necessary for the protection of human, animal or plant life or health, provided that such measures are not inconsistent with the provisions of this Agreement.

2.2. Members shall ensure that any sanitary or phytosanitary measure is applied only to the extent necessary to protect human, animal or plant life or health, is based on scientific principles and is not maintained without sufficient scientific evidence, except as provided for in paragraph 7 of Article 5\*.

2.3. Members shall ensure that their sanitary and phytosanitary measures do not arbitrarily or unjustifiably discriminate between Members where identical or similar conditions prevail, including their own territory and other Members. Sanitary or phytosanitary measures shall not be applied in a manner which would constitute a disguised restriction on international trade.

2.4. Sanitary or phytosanitary measures which conform to the relevant provisions of this Agreement shall be presumed to be in accordance with the obligations of the Members under the provisions of the GATT 1994 which relate to the use of sanitary or phytosanitary measures, in particular the provisions of Article 20(b).

\*Paragraph 7 of Article 5 sets conditions for Members to provisionally adopt sanitary and phytosanitary measures on the basis of available pertinent information in cases where relevant scientific evidence is insufficient.

## Bias towards trade

As part of Article 20, governments are given rights to adopt or enforce measures to protect human, animal or plant life or health. However, the nature of these necessary public health measures is not defined and in the process of dispute settlement there is a danger that the decisions of the WTO dispute settlement body will prioritise the interests of trade and restrict definitions of what are considered to be necessary public health measures.

This is more likely because of the nature of the dispute settlement body itself. The settlement process operates behind closed doors and members of the panels in dispute settlement bodies represent trade administration and trade law expertise. The importance of the dispute settlement

process is that it provides a set of cases and case law interpretations on various issues. The settlement panel may seek information from any relevant source and consult experts, and with respect to factual issues concerning a scientific or other technical matter a panel may request an advisory report in writing from an expert review group. However, whilst expertise on health and social policy issues may be heard in the panel discussion, decisions of panels are not made on the basis of the judgements of these experts.

### Comparing “like with like”

The WTO agreement stipulates that in a trade dispute products must be compared to “like” products without consideration of the methods or practices which have produced them. Thus a country should not exclude a good produced in a foreign nation, even if they deem that the production of that good involves risks to health or society. For example, a country should not ban imports of foreign beef derived from cows fed with antibiotics or hormones, even if local regulations ban or limit such practices. The United States has argued that genetically modified (GM) products are technically “like” to non-GM products, especially in those cases where genetically modified organisms have only been used in part of the production process, and so countries have no grounds for imposing import restrictions. Similarly, products made by compromising labour rights and/or safety standards are considered to be identical to those which have been produced with respect for these standards.

The requirement to treat “quite like” products as “similar” even though they might differ in fat, alcohol, salt, fibre or any content whose level is important for health, could also complicate government attempts to promote healthier diets. Similar problems would arise if countries restricted access, imposed higher taxation or set higher prices for products with negative health impacts, even though the products themselves would not pose any immediate health danger. While it has been suggested that trade in hazardous products should be outside WTO agreements, or at least set out in exceptions, problems relating to the use of economic incentives such as taxation to guide consumption towards healthier alternatives would remain.

### “Least trade restrictive measures”

Dispute settlement decisions made within the WTO framework to date suggest that “least trade restrictive measures” should be used to address public health and safety concerns. As a result there seems to be pressure to use labelling as a guide to matters of health concern in place of more systematic regulatory mechanisms – for example, taxation or banning of access, advertising or use.

Although labelling can improve consumer choice and address concerns about allergens in food, important debates about its efficacy remain. These include:

- (a) how far consumers can actually make a choice and how labelled products will be dealt with in mass-catering;
- (b) how much data can be presented on labels and how far this represents a real exchange of information;
- (c) the extent to which labelling represents an “individualisation” of regulation, with responsibility for decisions about difficult health and safety issues being passed on to consumers. The process of labelling could also be seen to be undermining the basic responsibilities of public health and environmental authorities to provide sufficient safeguards covering production processes.

## BOX 5.7

## Future disputes

Cases which will come to the dispute settlement panel in the future may well involve issues where scientific uncertainty is large or where regulatory measures are not very exact in their assessments of the risks of specific products, but geared more to addressing risky or problematic practices, misuse or abuse. These could cover, for example, the following issues:

- **Implementing precautionary measures in cases where scientific evidence does not exist or is problematic due to minor risks of widespread exposure which has potentially serious long-term implications – for example:**
    - substances with potential hormonal or carcinogenic impacts; bioaccumulative substances; substances with population-level associations with chronic diseases;
    - substances in relation to which prior knowledge of related substances suggests caution, such as stable organochlorine compounds or hormone derivatives.
  - **Regulating new or newly developed products where scientific evidence and risk assessment procedures may remain confidential and protected due to their commercial nature. For example**
    - GM foods, bio- and gene-technology products
    - newly developed pharmaceuticals, pesticides and other chemical products
    - food additives
  - **Implementing regulatory measures to deal with inappropriate measures in production methods which have broader health implications than simply those related to consumption or use of the end product. Examples include:**
    - GM foods and “terminator seeds” which may give only one crop
    - use of antibiotics and hormones in cattle breeding
- Implementing regulatory measures where the product as such may not be dangerous to health but where regulatory measures may be the least costly and easiest way of avoiding inappropriate use in the local context. This might include:**
- breast milk substitute marketing, marketing products for children
  - any products for which health impacts are related to inappropriate use (e.g., medicines).

## International trade and national governance

The international trade agreements hosted by the WTO are in principle still open to diverse interpretations. One important general interpretation implies that because nation members are supposed to ensure that their laws and measures are compliant with the negotiated agreements, this means that the interpretation of trade agreements will override national laws and considerations. In other words, should there be a conflict between a trade agreement and a national or international law, the latter would need to be revised. This implies that trade considerations rank higher than social and human rights and any other national or international legislation.

## International standards

The WTO agreements are based on relevant international standards. It is, however, not always defined who or what should be the body which sets the international standards, thus creating scope for industry-led self-regulation. While the SPS Agreement explicitly mentions some international benchmarks, there is clearly room for the development of commercially geared voluntary standards and codes of conduct which are lower than the standards of international regulatory agencies.

WTO standards with regard to food are defined by a recognised international body – the FAO/WHO Codex Alimentarius; but even here concerted lobbying by private interests could mean that future standard setting is compromised. Special attention has been drawn to the large share of non-governmental actors representing private sector interests in the Codex Committees in comparison to other non-governmental bodies. In the period 1989-

1991, 96% of non-governmental participants on Codex Committees represented industry.

Other well-established international bodies might find their guidelines ignored. For instance the International Agency for Research on Cancer (IARC) studies on carcinogenicity received little consideration in the beef-hormone case, which has been fought between the United States and the EU.

## Precautionary principle and risk assessment

Attempts to narrow down the scope of risk assessment pose another challenge. There appears to be a shift towards defining risk assessment as a highly quantitative and scientific process which measures specific exposures generated by specific products. More general regulatory measures resulting from the application of the precautionary principle could become more easily challenged as arbitrary, even where legitimate concerns exist. One grey area is low-level exposures. Canada has challenged the EU's standards for exposure to asbestos which are stricter than those set out under Canadian regulations. Asbestos is an acknowledged carcinogen, however, the carcinogenicity of asbestos at low exposures is very hard to show, even when a known risk exists. There are several other areas (as shown in box 5.7) where scientific uncertainty is large or where regulatory measures currently in place are not geared to assessments of specific products. These areas have the potential to cause future disputes.

## Trade-related aspects of intellectual property rights (TRIPS) agreement

The protection of intellectual property is an expanding business, with huge numbers of patents, copyrights, trademarks and industrial design licenses being granted everyday. Registration of intellectual property rights has soared since 1977 when the World Intellectual Property Organisation's Patent Co-operation Treaty, which accepts a single international application valid in many countries, received under 3,000 requests for the granting of patents. In 1997 it received 54,000, equating to 3.5 million individual national applications. According to the director of research and development at one of the largest biotechnology corporations, "the most important publications for our researchers are not chemistry journals but patent office journals around the world".

A global agreement on property rights, the Trade-Related Intellectual Property Rights Agreement (TRIPS), was signed in 1995 and is overseen by the World Trade Organisation. TRIPS sets minimum standards of protection for all forms of intellectual property as well as the boundaries of governments' control over intellectual property issues (see box 5.8).

However, currently the protection of intellectual property rights largely benefit rich countries which have already industrialised. Industrial countries hold 97% of all patents worldwide, and 80% of the patents granted in developing countries belong to residents of the industrial countries. The irony is that most of today's rich countries took advantage of much looser intellectual property laws in order to industrialise.

### BOX 5.8

#### What is TRIPS?

**Intellectual Property issues were first raised under the General Agreement on Tariffs and Trade in 1986 to clamp down on trade in counterfeit goods. With many industrial countries interested in tying negotiations on trade liberalisation to tighter control over technology, this narrow focus was soon extended to include many other areas. The TRIPS Agreement, signed in 1995, affects such diverse areas as computer programming and circuit design, pharmaceuticals and transgenic crops.**

**Although each country implements intellectual property rights law at the national level, the TRIPS agreement imposes minimum standards on patents, copyright, trademarks and trade secrets. These standards are derived from the legislation of industrial countries, applying the form and level of protection of the industrial world to all WTO members. This is far tighter than existing legislation in most developing countries and often conflicts with their national interests and needs. Developing countries were given until 2000 to adjust their laws, least developed countries until 2005.**

**The WTO's TRIPS Agreement can be enforced through the integrated dispute settlement system. This effectively means that if a country does not fulfil its intellectual property rights obligations, trade sanctions can be applied against it – a serious threat.**

*Source: South Centre 1997 and UNDP, 1999*

## Patenting life

It is not only the quantity of patenting that has expanded, but also the range of patentable products. This increase has led to concerns related to the patenting of seeds, indigenous products and practices, and genetically engineered plants as well as chemicals and pharmaceuticals. Although naturally occurring substances are not patentable, even only mildly altered chemical substances are. Serious concerns have been expressed about the possibility of putting patents on biological materials, many of them traditionally used by ordinary people in the South. Although in 1990 world sales of modern medicines derived from plants discovered by indigenous peoples were estimated at \$43 billion, only a tiny fraction of this amount found its way back to those who had preserved the traditional knowledge of these medicinal plants or to the countries where the plants were found.

### BOX 5.9

#### A patent too far?

In 1995 two researchers at the University of Mississippi Medical Centre were granted the US patent for using tumeric to heal wounds. But in India this was a long-standing art, common knowledge and practice for thousands of years. To get the patent repealed, the claim had to be backed by written evidence – an ancient Sanskrit text was eventually presented as proof and the patent removed – but this only highlighted the absurd imposition of one culture's systems on another culture's traditions.

Source: UNDP 1999

### BOX 5.10

#### Definitions

##### **Compulsory licensing**

Compulsory licensing means that country effectively overrides the patent system to make its own supplies of an essential medicine without the permission of the originator company. Before issuing a compulsory licence, the country must, in most cases, try to negotiate a voluntary agreement with the patent holder.

##### **Parallel importing**

Parallel Importing effectively allows countries to “shop around” to buy lower-priced versions of a patented medicine. This is possible because prices of medicines vary greatly between countries. Parallel importing occurs without the authorisation of the right holder.

Source: VSO – Drug Deals: Medicines, Development and HIV/AIDS (2000)

In theory therefore developing countries, home to an estimated 90% of the world's store of biological resources, could benefit from the demands of biotechnology companies for the germ plasm found on their land. But in practice governments and local communities in poor countries rarely have the power to negotiate with bio-prospectors over access and royalties.

Arguments that the strict defence of intellectual property rights is good for poorer countries are overstated. Although it has been claimed that the introduction of TRIPS would stimulate the transfer of technology, encourage foreign direct investment, strengthen research and development and innovation and ensure the early introduction of new products in developing countries, there is little evidence in support of these assumptions. On the contrary, the distributional impacts of TRIPS may in practice shift resources from consumers, the public sector and developing countries to multi-national research-based industries: this is an especially relevant consideration with respect to health technologies, biotechnology and genetechnology products and pharmaceuticals.

## Pharmaceuticals

The clearest health implications of the TRIPS Agreement for rational drug use flow from its impact on pharmaceutical policies and the cost of drugs. Tighter intellectual property rights may increase prices and undermine government scope to produce cheaper alternatives. The interpretation of the agreement has become particularly important in relation to measures such

as compulsory licensing and parallel imports which give governments more leeway in pharmaceutical policy-making. While essential drugs to a large extent fall outside the domain of patent rights, this is not the case for new drugs such as those used to treat HIV. The negative implications for Third World countries are thus potentially:

- Higher drug costs
- Larger foreign exchange outflow due to higher levels of imports and lower levels of exports
- Smaller employment generation due to lower domestic production.

The TRIPS Agreement implicitly assumes the positive implications for research and development of enhanced protection of intellectual property rights. However, it seems clear in the light of the minor share of resources currently allocated towards research on tropical diseases that the research and development efforts of the pharmaceutical industry (which are geared towards increasing shareholder value) may be directed more towards developing pharmaceuticals for problems where lucrative markets exist, such as cures for impotence, obesity, ageing, jet-lag and baldness.

<b>BOX 5.11 Benefits and drawbacks of trade in health services</b> (with particular reference to developing countries)		
<b>Service – What it means</b>	<b>Potential benefits</b>	<b>Potential drawbacks</b>
<b>Telemedicine</b> Patients can consult senior physicians; Medical students can follow up-to-date courses; Local clinics can send radiological images by satellite for inspection in specialist centres; Long-distance laboratory testing, diagnosis and treatment; Surveillance of disease patterns; Long-distance health service management	<ul style="list-style-type: none"> <li>• Could provide remote and underserved populations with access to services</li> <li>• Could advance clinical knowledge in under-resourced countries</li> <li>• Could promote international health objectives in disease surveillance</li> </ul>	<ul style="list-style-type: none"> <li>• Could divert money and skilled staff away from other parts of the health sector</li> </ul>
<b>Patients travelling for medical services</b> Countries can compete for patients by offering similar quality but lower-cost medical care; they can offer medical students courses	<ul style="list-style-type: none"> <li>• Could be a source of foreign exchange for developing countries</li> </ul>	<ul style="list-style-type: none"> <li>• Will it reduce access for domestic patients? Will students seeking medical education abroad return? If they return, will there be a mismatch between their skills and the needs of their country?</li> </ul>
<b>Foreign investment</b> A supplier of health services or health insurance might set up business in another country (there is actually little evidence of this happening in poor countries, where only a small percentage of the population can afford private treatment)	<ul style="list-style-type: none"> <li>• Might provide better health services – stimulate competition</li> </ul>	<ul style="list-style-type: none"> <li>• Could promote a two-tier health service, with wealthier sections of the population using foreign supplied health services</li> <li>• Could lead to an internal brain-drain</li> <li>• Could lead to “cream-skimming” by private insurance companies, who will select only low-risk clients, leaving the public sector to manage the costs of the higher-risk population</li> </ul>
<b>Movement of people supplying services</b> Health professionals moving to other countries	<ul style="list-style-type: none"> <li>• Health professionals gain knowledge from working in other countries which can be useful for the domestic health service</li> </ul>	<ul style="list-style-type: none"> <li>• This can be especially costly for poor countries, who see large amounts of health professionals leave to work in more developed parts of the world. This process can produce staff shortages and reduce the range of services available domestically.</li> </ul>

Source: adapted from WHO (1997)

## General Agreement on Trade in Services (GATS)

The negotiations on the GATT also ended with the formulation of a General Agreement on Trade in Services. This agreement will hold direct implications for future provision and utilisation of health services and may well help promote:

- The emergence of telemedicine – which enables consultation and learning as well as medical surveillance and laboratory testing to take place at considerable distances. This could provide remote and underserved populations with access to health services and promote international health objectives in disease surveillance.
- Greater foreign investment in health services, which could stimulate competition resulting in the provision of better health services for the local population. Poor countries which offer low-cost medical care could earn foreign exchange income from individuals from richer nations who travel abroad to seek treatment.

Again, however, benefits have to be weighed against costs: foreign investment may promote a two-tier health service, with wealthier sections of the population using foreign-supplied health services which attract staff and resources from the domestic sector. And if low-cost medical services are offered to foreigners, it may reduce access for domestic patients.

## GLOBAL VILLAGE – GLOBAL KNOWLEDGE

One positive aspect of increased international integration is the possibility of learning about other cultures, knowledge, experience and value systems. For instance, experience from developing countries could usefully inform how we approach health and run health services in the UK.

## Under fives clinic – integrating prevention with cure

The concept of the integrated under fives clinic (UFC) was developed by David Morley in Nigeria in the 1960s. The idea was that prevention was offered to children attending for treatment and children attending for immunisation or weighing could be offered treatment. This was a contrast to the previous idea that separate services were needed and that it would be potentially harmful for well children to share a waiting room with sick children because of the infection risk. The concept was successful and has been adopted throughout the developing world. In the UK, too, it was considered wrong to combine prevention and treatment, and preventive services were quite separate from curative. Now they are integrated in general practice though “well baby clinics” are on different days. However it is expected that children requiring treatment would receive it, and children attending a surgery should have their preventive needs addressed as well as curative.

## Growth monitoring and home-based records

David Morley also conceived the idea of growth monitoring and the home-based growth chart (“The Road to Health Chart”) which is in universal use in developing countries. Growth monitoring is still part of the UNICEF child survival programme (GOBI – FFF) though its effectiveness has

been questioned in recent years. There is now much interest in growth monitoring in the UK in relation to the detection of failure to thrive (weight) and short stature (height). Special charts have been published which make use of Third World experience of growth failure. We also have learned of the pitfalls of growth monitoring in the form of health worker tendencies to plot the weights incorrectly, and hence the need for careful training.

The home-based chart is now in widespread use in the UK as the personal child health record (PCHR) which includes a record of surveillance checks and immunisation as well as growth charts. Research is still being carried out on how to use the PCHR to improve communication between health professional and parents.

### **ORS and diarrhoea control**

As a result of Third World experience, oral rehydration is now generally used in the UK primary care in place of drugs which were the universal panacea. Parents are educated to look out for the signs of dehydration as they are in developing countries. However vigilance is still needed as drugs are still available and it is still common for infants with diarrhoea to be taken off the breast and starved, a regimen that is condemned in developing countries because of the risk of malnutrition and is quite unnecessary in the UK.

### **Breast feeding promotion and protection**

There is now a considerable literature on breast feeding promotion in developing countries, in relation to the training of health workers, the provision of protocols, community support, employment practice and the application of the Baby Friendly Initiative. In the UK, we are lagging behind in all these areas though there is considerable interest in Baby Friendly and a community initiative is being developed at present.

The application of the WHO Code of marketing of breast milk substitutes is highly relevant to the UK. Health workers need to understand its contents, its universal applicability and importance and why it matters in the UK; they need to examine why violations of the Code by infant formula manufacturers are common, what the effects are on breast feeding and what action health workers and their professional organisations can take. The influence of UK practice on developing countries should also be recognised.

### **Immunisation**

It is not many years since the immunisation rate in the UK was lower than in a number of African countries. Since that time, we have improved our performance but we can still learn from their experience, in relation to education on immunisation, the use of mass campaigns and achieving high coverage.

## Community development and empowerment

This is perhaps the area where most can be learned from developing countries. It is in the “hard to reach communities” in inner city areas affected by poverty that the approach is most needed, and there is now broad Third World experience to show us the way. The essence of this approach is that health improvement is not possible without the involvement of communities and in particular of the disenfranchised members of each community, for example women and the disabled. There is a need to listen to local people, to consult genuinely (usually consultation is lip service) and to involve them in service planning especially if changes in health behaviour are required. Members of marginalised communities such as slums, squatter camps and refugees feel disempowered and will not readily participate: community development is the process of empowerment. Health services in the UK have not been good at genuine consultation and yet the finding is that communities respond very positively if given the chance to do so by health professionals who work closely with them.

## Health education, child to child

Health education as practised in developing countries includes empowerment and should be education for life and not just in health behaviour. In the UK much health education is simply directed at the individual's behaviour and this is likely to be ineffective. In developing countries innovative techniques have been used involving music and drama, and we can learn from this. A specific method developed for child health education is the Child-Child programme which is based on the premise that older children in developing countries are often carers for younger children. The approach builds on this to teach the children about improving health behaviour, in their role as carers. A development of this is peer education programmes whereby older teenagers teach younger ones about health improving behaviour, e.g. in sexual health. This approach is particularly suitable to developing countries where teenage health is of increasing concern and conventional methods of health education are not very effective because young people reject adult messages which conflict with peer lifestyle concepts.

## Training of paramedics and PAMs

In most developing countries, paramedics take on many of the responsibilities of doctors with a much shorter training. They can do this effectively as long as there is adequate supervision and the development of appropriate guidelines. Now in the UK there is interest in similar approaches in specific situations such as special care baby units and primary health care teams. In the latter the nurse practitioner is being developed as a first-line nurse for specific situations and the experience of developing countries in relation to supervision and a career structure will be invaluable.

## Appropriate technology for health care

This means the application of low-cost technology which is up to date and relevant to the situation. Examples are solar energy for fridges, nursing preterm infants next to their mother's body for warmth and easier feeding and the use of compact haemoglobinometers for the detection of anaemia. This principle is equally applicable to developed countries where technology costs are a growing burden on health care budgets.

## UN Convention on the Rights of the Child

The UN Convention on the Rights of the Child was established with the needs of developing countries in mind, to protect children from exploitation and ensure that they receive priority in legislation and in the provision of health services. The relevance of the Convention to the UK is great and especially Article 12 which stresses the need to listen to the views of children and young people in all situations which concern them. Yet there is little awareness of the provisions of the Convention in the UK and little education of health workers on its significance; it is common for UN charters to be disparaged in this country, or excluded from consideration because they are thought to apply to poor countries but not our own.

### QUESTIONS

**1** In Box 1, Kelly Lee outlines seven areas where globalisation poses important questions for health. Research one of these areas and present your conclusions as a short two page discussion paper.

**2** What is the TRIPS Agreement? How does it affect health?

**3** What implications for health service structures would arise from increased movement of health consumers?

**4** What economic changes has globalisation entailed? What are the health effects of these changes?

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### Links to other opinions

Pharmaceutical Research and Manufacturers Association of America [www.pharma.org](http://www.pharma.org)

European Commission [www.europa.eu.int/comm/dgtrade](http://www.europa.eu.int/comm/dgtrade)

World Bank [www.worldbank.org](http://www.worldbank.org)

World Trade Organisation [www.wto.org](http://www.wto.org)

Oxfam [www.oxfam.org](http://www.oxfam.org)

WTO Watch [www.wtowatch.org](http://www.wtowatch.org)