

# World Trade Organisation: Implications for Health Policy



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## Overview

***The World Trade Organisation is set to become one of the most important influences on international health today. This briefing 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 ability of countries to run cost-effective and equitable health systems***

***The briefing warns that WTO agreements hold vast implications for policy-makers and others involved in health debates in both developed and developing nations.***

## Introduction

Trade has always had both positive and negative implications for health. Increased trade between nations may enhance economic growth and equity and thus be beneficial for health. However, it is also well-recognised that trade can bring with it substantial health problems. It can undermine incomes and livelihoods; and trade in living substances carries with it the threat of transfer of infectious agents.

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.<sup>1</sup> This growth is projected to continue, boosted by the establishment in 1995 of the World Trade Organisation (WTO), 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 1). 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 and human rights activists.

Nevertheless, previous successful rounds of negotiations mean that the WTO already has large implications for health and health policies. Some health policy commentators are now arguing that the WTO is one of the most influential international agencies with respect to health,<sup>2</sup> and yet the likely impact on health of the organisation and the policies it is promoting has not been given very much attention. This briefing discusses some of the implications of WTO agreements for health policy.



## 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 2).

### 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

#### BOX 1

#### The World Trade Organisation (WTO)

***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'.

**Sources: Kinnon, WTO: What's in it for WHO? WHO Task Force on Health Economics (Geneva, 1995); WTO. The Organisation Members. <http://www.wto.org/wto/about/organsnb.htm> updated 21/12/99.**

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.<sup>3</sup> 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

### BOX 2

#### **The health related exceptions in Article 20 of General Exceptions in the General Agreement on Tariffs 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**

#### The 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.*

(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,<sup>4,5</sup> 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.

### 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.



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## Agreement on the Application of Sanitary and Phytosanitary Measures (SPS)

This agreement deals with issues related to food safety and animal and plant health regulations.

The agreement:

- encourages members to base their measures on international standards, guidelines and recommendations where they exist;
- recognises the rights of governments to take sanitary and phytosanitary measures but stipulates that they must be based on science, and should not arbitrarily or unjustifiably discriminate between member nations where identical or similar conditions prevail.

The SPS Agreement has some important implications.

### *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-g 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.<sup>6</sup>

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.<sup>7</sup>

### *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.<sup>8</sup> Asbestos is an acknowledged



Genon Jensen, EFPA

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 3) 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.

In general it seems highly problematic for trade law and trade policy professionals to be making major judgements on the legitimacy of national regulation in areas such as health, especially in the absence of an open process and public scrutiny. The creeping impact of the WTO should not mean that decision-making in public health policies is shifted towards people working in trade departments.

### BOX 3

### 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 genetechnology 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).

## Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement

This agreement sets minimum standards of protection for all forms of intellectual property, including for example patents, copyrights, trademarks and industrial design licenses. In addition to this the TRIPS agreement sets rights and obligations for governments in terms of their ability to limit these rights for public purposes as well as to ensure that undisclosed information is protected if it is of commercial value.

Tighter intellectual property rights can disadvantage developing countries in two ways: by increasing the knowledge gap and by shifting bargaining power towards the producers of knowledge, most of whom reside in the industrialised countries. This shift might be particularly strong with respect to the effects of patents on the prices of medicines, due to the weak bargaining power of developing countries when negotiating prices with monopoly suppliers. While counter arguments have emphasised the fact that essential drugs are outside patents and part of the public domain, this is not the case for all drugs, such as those for HIV, and concerns over diminishing access to essential drugs have also been presented in the WHO and elsewhere.<sup>9</sup>

<sup>10 11</sup>

### *Patenting and intellectual property*

The interpretation of the intellectual property rights agreement has led to concerns related to the patenting of seeds, indigenous products and practices, genetically engineered plants and chemicals and pharmaceuticals. Although naturally occurring substances are not patentable, even only mildly altered chemical substances are.<sup>12</sup> Serious concerns have been expressed about the possibilities of putting patents on biological materials, many of them traditionally used by ordinary people in the South.<sup>13 14</sup> Shiva has noted that transnational corporations which accuse the Third World of piracy and who have demanded TRIPS to stop this piracy are themselves engaged in large-scale plundering of biological wealth and intellectual heritage from the Third World, including medicinal plants.<sup>15</sup> In 1990 world sales of modern medicines derived from plants discovered by indigenous peoples were estimated at \$43 billion, but 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.<sup>16 17 18</sup>

Although it has been claimed that the introduction of TRIPS would stimulate 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.<sup>12</sup> 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. In fact the TRIPS agreement was basically a compromise towards United States industries which had lobbied hard for it.<sup>19</sup> The United States pharmaceutical industry has continued lobbying on the agreement and watches country compliance.<sup>20</sup> According to the TRIPS agreement, there is no longer any obligation on firms to work the patented innovation in the country where it holds the patent and thus the agreement is consistent with the trend towards the internationalisation of production and marketing by multinational companies.<sup>12</sup>

## Pharmaceuticals

The clearest health implications of the TRIPS agreement for rational drug use flow from its impact on pharmaceutical policies, the allocation of patent rights and the cost of drugs. The interpretation of the agreement is of importance with regard to measures such as compulsory licensing and parallel imports which give governments more leeway in pharmaceutical policy-making: a dispute in this area has already arisen between South Africa and the United States.<sup>21</sup> While essential drugs to a large extent fall outside the domain of patent rights, this is not the case for new drugs used to treat HIV. The negative implications for Third World countries are potentially:<sup>22</sup>

- Higher consumer prices for drugs
- Larger foreign exchange outflow due to higher imports and lower exports
- Smaller employment generation due to lower domestic production

Concerns over the implications of the TRIPS agreement were raised in the context of the WHO resolution on essential drugs. The resolution faced substantial opposition when presented in its original form at the 1998 World Health Assembly, but it was accepted in a slightly revised form unanimously at the 1999 WHO Executive Board and at the subsequent World Health Assembly.<sup>23</sup>

The TRIPS agreement implicitly assumes the positive implications for research and development of enhanced protection of intellectual property rights. However, it seems clear that in the light of the minor share of resources currently allocated towards research on tropical diseases 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. The turning away of the pharmaceutical industry from research on tropical diseases has already caused concern.<sup>17 18 24</sup> Additionally, a whole new generation of costly genetics-based pharmaceuticals is expected to arrive in the future. Debates may arise around chemoprevention where the cost of pharmaceuticals may be substantial due to the broad populations subject to medication, leading to an increase in medicine costs for the public sector.

The current TRIPS agreement allows members to exclude from patentability diagnostic, therapeutic and surgical methods used for the treatment of humans and animals.<sup>25</sup> It may be expected that substantial industry interests will be focussed on narrowing these parameters in order to allow more space for the commercial exploitation of innovations emanating from the



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health care industry. So additional concerns have been raised about plans for broadening the scope of intellectual property rights to encompass medical and health technologies and issues such as surgical, diagnostic and therapeutic methods. Also of concern are the consequences of enhanced protection of intellectual property rights for the practice of medicine and dissemination of information.<sup>26</sup> Unanticipated side-effects of better protection of intellectual property rights might include the privatisation of knowledge, restrictions on the dissemination of information and a fundamental shift in the nature of scientific exchange and practice.

### *Trademarks*

TRIPS is not linked solely to patenting issues, but also covers trademarks and related aspects of commercial rights. This may cause legislative problems where tobacco, alcohol or infant formulas are advertised in an inappropriate manner or where indirect advertising is used through the placement of a logo – for example in tobacco advertising where cigarette-brand logos are placed on boots and clothes. This has been one of the ways in which the tobacco industry has circumvented national bans on advertising.<sup>27</sup> In some countries, such as Finland, public health-based legislation has forbidden this type of indirect advertisement. However, public initiatives to ban or restrict the advertisement of products such as infant formula, alcohol or tobacco may be construed as discriminatory measures which support local industries to the detriment of foreign producers because the former do not need to present or market their trademarks for the public in the same way as foreign producers who need to make their brand or trademark known.

In the WTO the role of countries and governments in the appeal and dispute settlement process has so far restricted or influenced appeals concerning hazardous products. However, while actual cases may not necessarily reach the stage of dispute settlement, the mere chance of threat may be sufficient for governments to allow foreign companies more scope for action if nations can be bullied with the threat of trade sanctions or a dispute settlement appeal.

### *Data access and regulation*

The TRIPS agreement does not only guarantee rights but also sets responsibilities which may become problematic in the more contested environment of government regulation of contracted-out services. Under the terms of the TRIPS agreement governments make commitments with regard to commercial information and its accessibility. The whole issue of access to information may become problematic in cases where there are potential public health implications, and also during the more mundane efforts to ensure the quality and cost control of contracted services or products that have been purchased by the health service. Firmer limits on access to information may also hinder citizens and consumer groups from following-up their right to know or understand the basis of decisions made in the public sector.

As part of the protection of intellectual property rights the agreement obligates governments to protect data and information used in the approval of licensed medicines and new chemicals. It is clear that too strict data confidentiality measures may hinder or prohibit early action in cases where there might be a reason to re-evaluate licensing decisions that have been made. The potential for this kind of problem to appear is more obvious in the broader arena of medical

research and the assessment of health technology, as much clinical research is funded by the private sector and private sponsorship is frequently sought for research. There is a danger that further protection of intellectual property rights may lead to a shift of innovation and research discussion away from the public and open sphere of scientific exchange towards private sector actors and networks hosted by them.<sup>26</sup>

## General Agreement on Trade in Services (GATS)

According to Adams and Kinnon, national health systems are becoming increasingly linked with various aspects of globalisation – one of which is trade. Regulations and standards intended to ensure the quality and safety of health services will increasingly be established on an internationally agreed basis. This means that governments, when framing policy, setting standards and drafting legislation will have to take account of the international context.<sup>28</sup>

The role of the GATS Agreement in relation to health and other public services has so far been limited as in many countries these services are provided by government. However, the rapidly increasing privatisation of public sector services provision and the enlargement of contractual arrangements in the public sector may change the picture fast, creating conditions for an increase in the role of private actors as well as providing possibilities for competition in the sphere of government contracting and procurement – it should be noted that the latter were put on the WTO agenda at the Singapore Ministerial Conference in 1996. In all areas of the GATS Agreement, restrictions have been set by governments on the potential for the opening up of health and social services. However, there are increasing pressures to allow market access as it has been estimated that government procurements may cover as much as 15% of national GDPs.<sup>29</sup>

In the context of health care services, the health care and public sector reforms advocated by international organisations such as the World Bank and OECD have paved the way for these

### BOX 4

#### The GATS Agreement

The GATS Agreement contains five components:

- (1) General Provisions (Part I) and general obligations and disciplines (Part II) that apply across the board to measures affecting trade in services;
- (2) Specific commitments (Part III) on market access and national treatment that apply only to sectors inscribed in a Member's Schedule;
- (3) A commitment by Members to enter into successive rounds of negotiations aimed at progressive liberalisation (Part IV);
- (4) Institutional provisions (Part V) and final provisions (Part VI); and

- (5) Various attachments, mainly in the form of sectoral Annexes and Ministerial Declarations.<sup>41</sup>

Future negotiations on the GATS agreement will centre on four areas:

- cross-border trade (e.g. telemedicine or internet services);
- movement of persons supplying services (e.g. movement of physicians, nurses etc. to work in other countries);
- foreign commercial presence (e.g. international hospital and managed care chains);
- and movement of consumers (e.g. health resorts and tourism).

developments. In addition, concerns about cost-containment have in many cases led to increases in cost-sharing or the off-loading of those willing to pay for health services onto the private sector.

Rather than an explicit policy, these pressures seem to be promoting an incremental process of government retrenchment and private sector enlargement. This process is often justified as a means of improving competitiveness, in spite of the fact that, in terms of national competitiveness the total cost of care should be the determining factor.<sup>30</sup> The problem with this trend in the context of healthy public policies is that the privatisation and introduction of competition in health care has not delivered the gains that were promised and in many countries the results have been dismal. It follows that there is a danger that the promotion of international trade and privatisation of health services will in fact lead towards the development of less effective, costlier and inequitable health systems.

This means that while trade in services is not yet perceived as an issue, there is a potential that health care markets will be formed in health systems which are currently based on social insurance and in national health systems, either through an increase in the role of private financing or as a result of higher levels of public contracting. The advent of technologies such as telemedicine could also make operations across distance easier and facilitate global health care operations and trade in health services.

In developing countries, non-governmental organisations have so far played a more prominent role in health care than for-profit actors. Yet an expansion of trade in health services and investments in health in the developing world could be of major interest to multinational actors, especially in those countries with a sufficiently affluent elite willing to pay or with a private health service base. Thus international health care markets could develop in Latin America, South East Asia and China. Latin America, South East Asia and the Pacific Rim have already been mentioned as potential areas for managed care.<sup>31,32</sup> The expansion of private care in Latin America has been noted,<sup>33</sup> and heavy criticism has also been cast on the marketing of managed care in Latin America and support of this by international financial institutions such as the IMF and World Bank.<sup>34</sup> While it may be argued that the private provision of publicly-financed health care should not make any difference, recent experiences in the United States with respect to the quality of care provided by managed care organisations raises doubts about the appropriateness of this practice.<sup>35</sup> Although international agreements on trade ensure the rights of transnational health care and health-related industries, they may in practice also effectively limit government capacity to impose regulatory measures, and enhance the privatisation, commercialisation and multinationalisation of health care. This may be more likely in developing countries, where in general there is even less government steering, and more scope for private sector involvement as private financing of health care is already substantial.

### *Equity and markets in health care*

The principle of equity in health care is seen as being guaranteed by two mechanisms: the provision of services according to need and the financing of those services according to ability to pay.<sup>36</sup> A comparison of different finance mechanisms for service provision suggests that progressive taxation and public provision is the least regressive approach whereas financing

through private insurance and out-of-pocket payments is the most regressive. Universal insurance systems fall somewhere in the middle.<sup>37 38</sup> In the United States the presence of strong private actors has meant that while a large proportion of the population remains uninsured and without access to health care services, health spending as a percentage of GDP is the highest in the world and substantial private cost-sharing also exists. In short, there is a danger that policies implemented as part of the GATS, promoting international trade and the privatisation of health services, may have unanticipated consequences and will in fact lead to the development of less equitable – and costlier – health systems.<sup>39 38</sup>

### *Future trade-creep in services provision and insurance markets*

The important issue is to what extent the WTO stipulations on government procurement practices, competition and trade in services will influence national, regional or local service provision in the future. As government procurement of services has so far been defined outside the agreements, the inclusion of a plurilateral agreement on government procurement might add an important link enabling competitive bidding for various public sector services at the global level, but without due consideration for its implications in terms of:

- How services will be regulated at the international level
- The emerging role of the pharmaceutical industry as owners of service providers
- Issues of data protection and the secrecy of commercial information
- Equity in access and financing and the control of public sector costs
- The indirect effects on health of the liberalisation of insurance and pension services

It is important to realise that the WTO approach to health systems considers them in the same way as other services as a recent paper presented in the Council for Trade in Services suggests:<sup>40</sup>

*... the picture seems to be gradually brightening over time, owing in particular to two complementary developments: first, regulatory regimes in various countries have been moving towards stronger market orientation – opening space for private involvement, domestic and foreign – and, second, technical changes are increasingly enabling certain services or at least sub-services, to be transmitted electronically between countries and continents.*

This discussion paper from the WTO secretariat clearly shows both the market-orientation of the approach taken towards the subject and a lack of understanding as to why trade in health services might be different from trade in services generally.<sup>40</sup> The danger is that during the negotiation process on the GATS Agreement and the Agreement on Government Procurement too much emphasis will be put on increasing the export potential of private providers without adequate consideration of the gradual impact of private sector interests on the nature and structures of health systems as a whole.



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# Agenda for Action

*The powers of the WTO stretch across many areas fundamental to health policy including public health regulations, access to essential medicines, ability to regulate product promotion, and the development of equitable and cost-effective quality health systems. Keeping this in mind we make the following general suggestions:*

- 1** There is a need for a full review of the current state of the WTO agreements and their implications for health and social policies;
- 2** National level Ministries responsible for health and social policies should be adequately informed about these implications and have the capacity to analyse policies and bring forward their views as part of democratic governance;
- 3** At the international level, disputes about issues concerning public health and safety, labour rights and environmental sustainability should be shifted to more appropriate forums such as the specialised UN agencies rather than being dealt with in the closed dispute settlement body of the WTO;
- 4** Agreements made in the WTO should allow for fair treatment of poor countries and for ethical, social, distributional, health and environmental concerns. The influence of strong transnational actors and lobbying groups for private industries should be balanced and efforts made to address the representation needs of less powerful actors.

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