Globalization, Health, and the Free Trade Regime: Assessing the Links

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ABSTRACT

Globalization can be defined as the increased interconnectedness of peoples and nations through technology, trade, and finance, reinforced by an increasing number of multilateral institutions and rules. Globalization can bring health benefits, but is also associated with health risks. Its direct and indirect links to health present a complex puzzle. This essay provides a framework to help in unpacking the links, including a review of some of the evidence of health impacts along the pathways. Particular attention is given to trade agreements and their potential effects on national regulatory abilities to create healthy living, working, and environmental conditions.

Introduction**

Globalization describes a process by which nations, businesses and people are becoming more connected and interdependent across the globe through increased economic integration and communication exchange, cultural

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diffusion (especially of Western culture) and travel. It is not a new phenomenon. One might actually call it a basic human drive. Jared Diamond (2000), in his book, *Guns, Germs and Steel*, recounts how the history of humankind has been one of pushing against borders, exploring, expanding, conquering and assimilating. In ancient Western times, "global" meant the Middle East, once a Garden of Eden that, despoiled by overuse, became an eroding desert that drove people further east to what is now China and west to the Mediterranean and continental Europe. In Western medieval times, "global" meant exploration, colonization and exploitation of the "new world." Eduardo Galeano (1973) thirty years ago, in his polemic, *Open Veins of Latin America*, showed how only the wealth of the exploited colonies — their resources, their peoples — allowed Western capitalism to depose feudalism.

Contemporary globalization, abetted by innovations in communications technologies, is characterized by increasing liberalization in the cross-border flow of finance capital and trade in goods and services. It differs from previous eras in several ways:

1. The scale and speed of such movement, particularly of finance capital. Over US $1.5 trillion (some estimate $2 trillion) in currency transactions occurs daily, more than double the total foreign exchange reserves of all governments. Such transactions reduce the ability of governments to intervene in foreign exchange markets to stabilize their currencies, manage their economies and maintain fiscal autonomy (UNDP 1999).
2. The establishment of binding rules, primarily through the World Trade Organization. Trade agreements are increasingly establishing enforceable supra-national obligations on nation-states. Countries have also entered into scores of other multilateral conventions and agreements on human rights and environmental protection, but few of these carry any penalties. This asymmetry between enforceable economic (market-based) rules and unenforceable social and environmental reciprocal obligations may be the biggest governance challenge of the new millennium (Kickbusch 2000; Labonte 1998; UNDP 1999).
3. The size of trans-national companies involved, several of which are economically larger than many nations or whole regions. Much of the global trade in goods is intra-firm, meaning that a company's subsidiary in one country sells parts or products to a subsidiary in another country (Reinicke 1998). This allows companies to locate labor-intensive parts of the production chain in low-wage countries (often in exclusive export production zones) and to declare most of their profits in low-tax countries (leading to global tax competition

and lower corporate tax revenues in all countries). The Oxford Committee for Famine Relief (OXFAM) estimates that over US $100 billion in potential tax revenue leaves developing countries for offshore tax havens each year, almost double the total amount of aid they receive (Action Aid et al. 2001).

4. The apparent commitment of most countries to continue the project of global economic integration through increased market liberalization. This commitment is built upon two decades' dominance of neoliberal economic assumptions, reflected in the macroeconomic policies of most governments, the World Bank and International Monetary Fund, and most trade agreements (see Table 1). It is somewhat tempered by the reluctance of many of the world's wealthiest nations to abide by these assumptions if they are not to their benefit, witnessed by the continued presence and even increase of trade-distorting domestic agricultural subsidies in the European Union, Japan, and the United States.
5. Social, economic, environmental, and health issues are becoming "inherently global," rather than purely national or domestic (Labonte and Spiegel 2002). Environmental impacts of human activities are planetary in scale and scope; disease pandemics and economic stagnation partly underpin state collapse and regional conflict (Price-Smith 2002); almost 1/6th of humanity is "on the move" to escape environmental or economic degradation and conflict, straining against the borders of other nations (Worldwatch Institute 2001). The risk of a return to unilateralism by the more powerful nations is always present; the evidence of the need for multilateral (global) solutions is irrefutable.

From a health vantage, there are several compelling pro-globalization arguments. The diffusion of new knowledge and technology through trade and investment, for example, can aid in disease surveillance, treatment and prevention. There is also broad consensus on the positive effects of a globalization of gender rights and empowerment, though with the *caveat* that these rights are not simply an invention of the West but existed (often more strongly in pre-Western colonization times) in many presumably less emancipated countries today (Sen 1999). In economic terms, the pro-globalization argument posits that increased trade and foreign investment through liberalization can improve economic growth. Such growth can be used to sustain investment in necessary public goods, such as health care, education, women's empowerment programs and so on (Dollar 2001; Dollar and Kray 2000). Such growth, particularly in poorer countries, also reduces poverty, which leads, in turn, to better health. Improved population health, particularly amongst the world's

Table 1

Basic neoliberal economic assumptions drive contemporary globalization

Objectives	Recommendations and Benefits
Liberalization	Open markets work best for everyone
Privatization	States should not own or operate productive or profitable sectors of the economy
Private sector enhancement	States should not only sell off their assets, but also open their programs or services to private sector competition
Deregulation	The fewer the rules on the private sector, the better
State minimalism	States should reduce their public spending and taxation rates and introduces cost-recovery program to help pay their debts, balance their budgets, and promote the private sector

Adapted from Milward (2000).

poorest countries, is increasingly associated with improved economic growth (Savedoff and Schultz 2000; World Health Organization 2001) and so the circle virtuously closes upon itself.

Globalization's skeptics quickly point out that the virtuous circle can have a vicious undertow. This includes the more rapid spread of infectious diseases, some of which are becoming resistant to treatment; and the increased adoption of unhealthy 'Western' lifestyles by larger numbers of people (Lee 2001). The more significant challenge is that liberalization does not always or inevitably lead to increased trade, foreign investment or economic growth and that, when it does, it does not inevitably reduce poverty (Cornia 2001; Weisbrot et al. 2001). Much depends upon pre-existing social, economic and environmental conditions within countries; and upon specific national programs and policies that enhance the capacities of citizens, such as health, education and social welfare programs (UNDP 1999). China, Korea, Thailand, Malaysia, Indonesia, and Vietnam did increase dramatically their role as global traders, but this was primarily in terms of their exports. They maintained public ownership of large segments of banking, retained tariff and non-tariff barriers that shielded important sectors of their economy from competitive imports, and placed restrictions on foreign capital flows—which is precisely how wealthier European and North American economies developed historically (Rodriguez and Rodrik 2000; Rodrik 1999). World Trade Organization rules now largely prohibit poorer countries from doing the same, with only modest provisions for "special and differential treatment" (trade agreement exemptions) that are being actively opposed by many of the world's richest economies. Weaker economies with fewer domestic protections, largely removed through earlier World Bank and International Monetary

Fund (IMF) "structural adjustment" loan conditionalities, have fared poorly under liberalization, particularly those in Africa and Latin America. The net effect for these countries has been suppressed domestic economic activity, depressed wages and tax revenues, and worsened balance of payments (Sustainable Developments 2001). Mexico, Uruguay, Zimbabwe, Kenya, India, and the Philippines all witnessed serious declines in income and corresponding increases in poverty and poor health among its rural farming population following liberalization (Hilary 2001).

Understanding the Impact of Globalization on Health

Globalization may improve the health of populations in some circumstances but damage it in others, especially when liberalization has been rapid and without government support to liberalization-affected sectors and populations (Ben-David, Nordstrom, and Winter 1999; Cornia 2001; UNDP 1999). Liberalized trade in agricultural products, for example, may provide short-term economic benefit to less developed countries. This can improve citizens' health, depending on how equitably those benefits are allocated among all citizens. But food exports in poorer countries can also increase fossil-fuel based transportation, creating short- and long-term health- and environment-damaging effects; and commodity-led export produces lower long-term economic growth than manufactured ("value-added") export (Kim et al. 2000). Protectionist policies, including subsidies, in turn, may preserve rural life and livelihoods, which is an argument frequently advanced by the European Union and Japan (Labonte 2000). These policies benefit the health and quality of life of rural people. But such policies can also support ecologically unsustainable forms of production and increase oligopolistic corporate control over global food production. Another example of liberalization's mixed effects is that trade openness might increase women's share of paid employment, which is an important element of gender empowerment (Ozler 1999 in UNDP 1999). Yet much of women's employment remains low-paid, unhealthy and insecure in "free-trade" export zones that often prohibit any form of labor organization and employ only single women. Public-caring supports for young children have been declining in many trade-opened countries, portending future health inequalities. There is also evidence of a global "hierarchy of care." Women from developing nations employed as domestic workers in wealthy countries send much valued currency back home to their families, some of which is used to employ poorer rural women in their home countries to look after the children they have left behind. These rural women, in turn, leave their eldest daughter (often still quite young and ill-educated) to care for the family they have left behind in the village (Hochschild 2000).

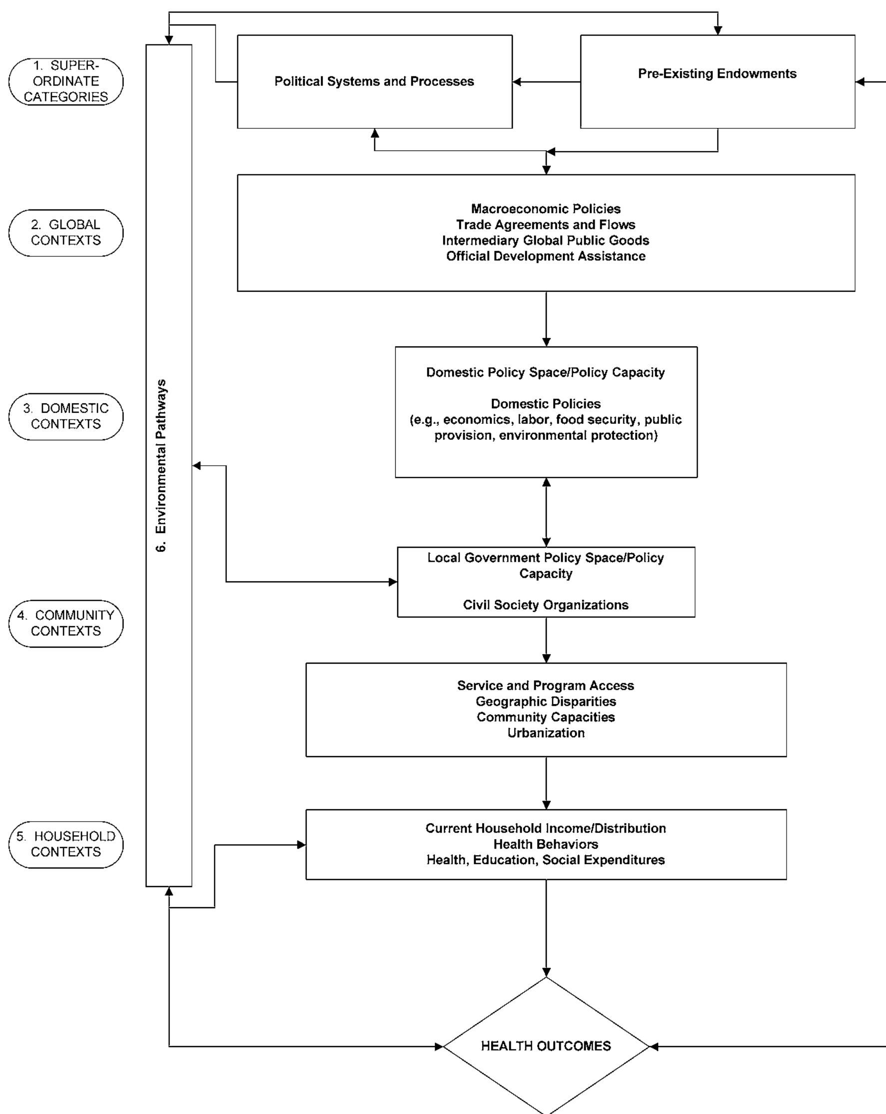

Figure 1. Globalization and health: selected pathways and elements.

What is the gain? What is the loss? Or, more poignantly expressed, who gains and who loses? Tracing the impacts of globalization on health to answer such questions can be a daunting task. Figure 1, based upon a more extensive study (Labonte and Torgerson 2002), provides a simplified framework for understanding how contemporary globalization can affect

health.[1] The key points conveyed by this Figure in descending order of scale are:

1. How contemporary globalization affects health depends, first, on the historical context of particular countries, specifically their political, social, and economic traditions (e.g., democratic, oligarchic, patriarchal, theocratic, dictatorial); and their stock of pre-existing endowments (e.g., level of economic development, environmental resources, human capital development).
2. Globally, the major vehicles through which contemporary globalization operates are imposed macroeconomic policies (notably Structural Adjustment Programs, which are the precursors of today's free trade agenda); enforceable trade agreements (notably the World Trade Organization) and associated trans-border flows in goods, capital, and services; official development assistance as a form of wealth transfer for public infrastructure development in poorer nations; and "intermediary global public goods," the numerous yet largely unenforceable multilateral agreements we have on human rights, environmental protection, women's rights, children's rights, and so on (Kaul, Grunberg, and Stern 1999; Kaul and Faust 2001; Sandler and Arce 2000).
3. These vehicles, in turn, have both positive and negative health effects on domestic policy space, by increasing or decreasing public sector capacity or resources and regulatory authority. Key domestic policies that condition health outcomes include universal access to education and health care, legislated human and labor rights, restrictions on health-damaging products such as tobacco, or exposure to hazardous waste and environmental protection. Liberalization, whether through trade agreements or through Structural Adjustment Programs, lowers tariffs on imported goods.[2] This affects the ability of policies to provide the public health, education, and water/sanitation services

[1] It is difficult to link directly health outcomes to globalization processes. Other phenomena may affect health status dramatically in the short-term, for example, infectious diseases such as HIV/AIDS, or large-scale immunization programs. These are largely independent of globalization processes, although mass communication, travel, and global economic pressures will change risks of exposure, and the Agreement on Trade-Related Intellectual Property Rights (TRIPS) is affecting access to treatment. Changes in physical environmental conditions, such as increasing the size of a nation's or population group's "ecological footprint," may improve health outcomes in the short-term but not over the long-term. Changes in international trade and investment flows are recent and present-day health gains, at least for older populations, may reflect social and environmental conditions of an earlier period characterized by greater trade protectionism and stronger state welfare programs.

[2] Liberalization therefore has been particularly hard on developing countries, which derive much of their national tax revenue from tariffs and which lack the capacity to

essential both to health and to economic development. Global and regional trade agreements, in turn, are increasingly circumscribing the social and environmental regulatory options of national governments. It is the impact of globalization at this level of national policy capacity and regulatory authority that causes health activists the greatest concern, since it can preclude governments from enacting those policies that lead to health, equity, and empowerment at the local levels.

4. National policies and resource transfers affect the abilities of regional or local governments to regulate their immediate environments, provide equitable access to health-promoting services, enhance generic community capacities (community empowerment), or cope with increased and usually rapidly increasingly urbanization.
5. At the household level, all of the above determine in large measure family income and distribution (under conditions of poverty, for example, when women control household income, children's health tends to be better), health behaviors, and household expenditures (both in time and in money) for health, education, and social programs.
6. Each level affects, and is affected by, environmental pathways, chief among these being resource depletion (water, land, forests), biodiversity loss, and pollution.

While much remains to be understood about how globalization phenomena can be harnessed to improve global health outcomes, we have now lived through 20 years of increased market integration and 10 years of enforceable trade rules. With respect to trends in two fundamental health-determining pathways (poverty/inequality, and environmental sustainability), the effects have been largely negative.

Poverty and Income Inequality

Globally, the past decade has seen a reduction in poverty rates at the $1/day level, but a worsening in such rates at the $2/day level (Ben-David, Nordstrom, and Winters 1999). This allows us to infer, somewhat cynically, that our recent era of globalization has successfully transferred income from the extremely poor to the absolutely destitute, a conclusion bolstered by more recent evidence that poverty rates at the $1/day level are once again increasing in the least developed countries (UNCTAD 2002). Some counter that this situation exists because poor countries have insufficiently liberalized. If they liberalized more, they would benefit more. A 1999

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institute alternative revenue-generating sources (Hilary 2001; Rao 1999; Rodas-Martini 1999; World Bank 2000).

UNDP study of 40 developing and least developed nations challenges this assumption. It found that trade openness (liberalization) increased poverty and inequality. Those countries liberalizing most rapidly fared worst (Rao 1999).

While there is still some controversy over whether trade liberalization will or will not succeed in poverty reduction—recalling poverty as one of health's greatest threats—there is much less dispute that trade liberalization is increasing inequality. Whether income inequality is the root of disease inequality remains a disputed topic among population health researchers (Deaton 2001). Poverty, which is higher in high income-inequality countries, may be the bigger problem. But the greater the income inequality, the harder it becomes for the economic growth *presumed* to follow trade liberalization to actually lift people out of poverty. Moreover, inequalities *are* associated with a decline in social cohesion, social solidarity and support for strong states with strong redistributive income, health, and education policies that have been shown to buffer liberalization's unequalizing effects (Deaton 2001; Global Social Policy Forum, 2001; Gough 2001).

The evidence that trade and investment liberalization is leading to growing income inequality is compelling. A review of 313 Structural Adjustment Programs (SAPs) from 1968 to 1994, which increased liberalization and privatization of public services, found that inequality measures worsened dramatically in the first three years following such programs (Lee and Rhea 1998 in Rodas-Martini 1999). While there was some improvement in these measures by the fifth year, they never recovered to their pre-SAP period. A recent review of the health consequences of structural adjustment (Breman and Shelton 2001) found a preponderance of negative effects among 76 studies identified; the impact of structural adjustments was almost singularly negative in Africa. David Dollar (2001) of the World Bank, however, argues that there is no consistent pattern between liberalization and income inequalities and that, on average, incomes in the bottom percentiles rise at the same rate as those in the highest percentiles as economic growth proceeds. Yet the same 10% rise on $1,000 and $100,000 nonetheless creates a larger absolute difference in wealth, health-enhancing capacities, and privileges. Moreover, the very countries cited as evidence of the liberalization, growth, and poverty-reduction relationship (such as China, Vietnam, and India) are the outliers among the average in terms of income distribution. Those market liberalizing developing countries experiencing the greatest growth are also the ones experiencing the sharpest increases in income inequalities.

The Environment and Sustainable Development

The two primary pathways linking globalization to the environment are the liberalization-induced effects of growth on resource depletion and pollution, and increased transportation-based fossil-fuel emissions. Ecological limits to growth and consumption are rarely considered in economic models, yet if all countries "developed" to the same consumption patterns found in the US, our species would require four more planets to exploit (*Footprint of the Planet Report* n.d.). Worldwide, current consumption outstrips capacity by 35%. There are also numerous case examples where trade and investment liberalization have increased the pace of environmental degradation, for example:

1. The combined effects of deregulation, privatization, and weak governmental controls on the Indonesian logging industry, implemented to increase economic growth through increased trade, have led to the loss of more than 1 million hectares of forest per year through logging in Indonesia. Health effects range from short-term and widespread respiratory disorders associated with extensive burning to long-term ecosystem disturbances and potential climatic change (Walt 2000).
2. In Uganda, trade liberalization in the form of industrial privatization and tariff reduction on fishing technology contributed to over-fishing of the Nile perch in Lake Victoria, and a degradation of the lake's ecosystem and water quality (UNEP March 2001).
3. Mauritania, a poor sub-Saharan African country, has sold fishing rights to factory-ships from Europe, Japan, and China to earn the foreign currency it needs to pay back liberalization-induced foreign loans. Meanwhile, fish, the staple protein for the country's poor, has largely disappeared from local markets (Brown 2002).
4. In Argentina, trade liberalization and promotion of fisheries exports led to a fivefold growth in fish catches in the decade 1985-95. Fishing companies gained an estimated US $1.6 billion from this growth, but depletion of fish stocks and environmental degradation have produced a net cost of US $500 million (UNEP March 2001).

There are also potential indirect climate change effects due to deregulation of foreign investment. A recent example of this was the Brazilian currency crisis of 1998, precipitated by the greatest inflow and outflow of speculative capital ever experienced by a developing country (de Paula and Alves Jr. 2000; UNDP 1999). The government lacked sufficient foreign reserves to stabilize its currency and was forced to borrow from the International Monetary Fund. The rescue package included the requirement for drastic public spending cuts, including a two-thirds reduction in Brazil's environmental protection spending. This led to the collapse of a multi-

nation funded project that would have begun satellite mapping of the Amazonian rainforest as a first step in stemming its destruction. This destruction, in turn, may have a profound effect on climate change, with long-term and potentially severe health implications for much of the world's populations (Labonte 1999). The 2002 World Summit on Sustainable Development commitment of the Brazilian government to set aside large tracts of the remaining Amazonian rainforest partly obviates this earlier bleak assessment (Mitchell 2002).

Most empirically based projections on the environmental impacts of trade liberalization show severe ecological damage (Labonte and Torgerson 2002). The only exception is trade agreement requirements to reduce trade-distorting agricultural and fisheries production subsidies. These subsidies go primarily to wealthier producers within wealthy countries, wreck havoc on local production in poorer countries by flooding the market with below-cost commodities, and severely damage the environment. World Trade Organization member nations in November 2001 committed themselves to "reductions, with a view to phasing out, all forms of [agricultural] export subsidies; and substantial reductions in trade-distorting domestic support" (WTO Doha Ministerial Declaration 2001). The EU and Japan, which heavily subsidize their domestic farmers, have been slow to comply; and the US Bush Administration in 2002, despite the Doha agreement, signed into law the largest increase in domestic farm subsidies in American history. [3]

World Trade Organization Agreements and Health-Determining Pathways

This discussion now shifts to a narrower focus on trade agreements, specifically those of the World Trade Organization (WTO) and their impacts on globalization's health-determining pathways. The WTO was formed in 1995 out of the Uruguay Round of talks on the General Agreement on Tariffs and Trade (GATT). The WTO is the only multilateral organization with enforcement powers in the form of fines or monetized trade concessions. It administers 29 different trade, investment, and "trade-related" agreements. Key principles underpinning all agreements are "national treatment" (in which foreign goods, investment or services are regulated the same as domestic ones); "most favored nation" (whatever special preferences might be given to one trading partner must be given to all

[3] The US Trade Representative, Robert Zoellick, subsequently proposed global reductions in such subsidies, including those in the US (*BRIDGES Weekly Trade News Digest* 6 [38] 7 November 2002). This is a common ploy by wealthier countries in the WTO. Before agreeing to reduce trade-distorting tariffs or subsidies in sectors important to their own economies, they first dramatically raise them.

member nations); and "least trade restrictive" (whatever environmental or social regulations a country adopts domestically that might fall within the ambit of WTO agreements must be those that least impede global trade). Several WTO agreements have specific bearing on these broad economic, social, and environmental pathways linking globalization and health.

There is growing consensus that various forms of social investment and worker protections are needed in the transition from a closed to open economy. But these very protections may be eroded through the new trade/investment regime. The Trade Related Investment Measures (TRIMS) agreement prevents countries from placing "performance requirements" on foreign investment. Such requirements have been used to benefit corrupt political leaders, government officials and their families. But such requirements have also proven useful in the development of viable national economies. Their removal benefits investors from developed countries much more than it does people living within developing countries. Many developing countries are requesting exemptions to this TRIMS requirement in order to retain some control over the direction of their local economic development. Such exemptions may prove difficult, since a WTO dispute panel several years ago ruled against the use of import protections by developing nations for purposes of improving poor living standards. "Development [or pro-poor] policy," the ruling concluded, is not the same as "macro-economic policy." Where there is a WTO dispute, the latter shall prevail (Raghaven 1999). Moreover, the exemptions to TRIMS for developing countries are opposed by the so-called "Quad" of rich countries — the US, the European Union, Japan, and Canada (*BRIDGES Weekly Trade News Digest* 6 [20], 28 May, 2002).

The Technical Barriers to Trade (TBT) agreement views any "technical" barriers to trade as restrictions that must be reduced to "international standards." A technical barrier is a domestic regulation that has nothing to do with tariffs (the taxes governments impose on imports) or export subsidies (the assistance they give to exports). The TBT agreement encourages use of international standards and allows domestic regulations to be higher only if they can be justified. Article XX(b) of GATT permits exception to the general GATT rules, including the TBT, that are "necessary to protect human, animal or plant life or health." On the surface, this exception seems to allow for a reasonable level of health protection. But in only one instance has this exception been successful in a trade dispute. In April 2001, the WTO rejected Canada's appeal against the French decree banning the importation of asbestos. Canada argued that its asbestos products were "like" the glass fiber products that France did permit; therefore the asbestos ban was a technical barrier to trade. The WTO dispute panel agreed with Canada, but also considered the large

body of research establishing asbestos as a proven human carcinogen. The French ban therefore qualified under the Article XX(b) exception (WTO 2000). Such scientific certainty, however, rarely applies to most human health risks, especially those mediated through the environment. Moreover, countries wishing to derogate from trade rules under this exception are responsible for proving that the measure is not really protectionism in disguise. Many health non-governmental organizations (NGOs) argue that a reverse onus should apply, that is, the complaining country should prove that the exception was *not* invoked to protect human, animal, or plant life or health.

Scientific uncertainty is the premise behind the "precautionary principle," that is, when evidence is suggestive but not conclusive, the benefit of doubt should go to protecting human and environmental health. This principle has been weakened by the Agreement on the Application of Sanitary and Phytosanitary Measures (SPS), which mandates a scientific risk assessment on all regulatory standards. Risk assessments, while an important tool in providing an understanding of human threats to the environment and, in turn, environmental threats to humans, cannot deal with the multiple, cumulative impacts which now typify risk management issues. The SPS risk assessment requirement invariably favors producers and exporting countries over citizens and importing countries, since there is no cost to them if, eventually, their product proves harmful. The higher order of scientific certainty under the SPS than that governing GATT Article XX(b) is one reason why the European Union (EU) lost to the US and Canada on its attempt to ban imports of hormone-treated beef. The WTO dispute panel, which did not include any scientists as its members, rejected as inadequate the EU arguments—including evidence of possible, though not definitive, human carcinogenicity—provided by the independent International Agency for Research on Cancer (Charnovitz 2001; Sullivan and Shainblum 2001). Both the TBT and the SPS constitute what some call "trade-creep," where trade rules limit how national governments can regulate their domestic health and environment affairs even if they treat products from other countries no differently than their own (Drache et al. 2002).

The Agreement on Government Procurement (AGP) requires governments to take into account only "commercial considerations" when making purchasing decisions, specifically banning preferences based on environment, human, or labor rights. Currently a plurilateral (voluntary) agreement to which few developing countries have signed on, there are plans for it to become a multilateral (mandatory) agreement (WTO Doha Ministerial Declaration 2001). Such an agreement might aid in preventing large-scale cronyism or abuse of public monies by corrupt officials. Like the TRIMS

agreement, however, it could also signal gradual erosion in the ability of national governments to give preference to domestic suppliers and so direct public revenues to groups or regions in greatest need of economic support and development. Many developing countries are asking for exemptions to the AGP, arguing that government procurement is one of the few means they have to develop socioeconomically disadvantaged areas, groups, or sectors (*BRIDGES Weekly Trade News Digest* 6 [21], 4 June, 2002). Again, most developed countries are opposing this.

Ironically, the Agreement on Trade-Related Intellectual Property Rights (TRIPS) does not "free" trade but is a trade "protectionist" by entrenching intellectual property rights, almost all of which are held by companies or individuals in developed countries. TRIPS requires WTO member nations to legislate patent protection for 20 years, although least developed countries have an exception extended until 2016. Debate over TRIPS, particularly regarding access to antiretroviral drugs, has been extensive and highly public. Few developing countries had any patent protection legislation prior to joining the WTO. One effect of the agreement has been sharply increased drug costs in most countries. This higher cost for drugs decreases the amount of public funding available for primary health care or other public programs, including environmental protection, in first world countries, where 75% of prescription drug costs are publicly or privately insured. But it is particularly hard on persons living in poor countries where the health portion spent on drugs is already much higher and often a direct personal cost.

Current TRIPS clauses allow countries to issue compulsory licenses to generic drug manufacturers in cases of public health emergencies. These provisions were affirmed by the so-called Doha "Declaration on TRIPS Agreement and Public Health" (WTO 2001). [4] While lauded as a major public health breakthrough and a victory by developing countries (particularly the group of African countries) at the WTO, the Doha Declaration failed to deal with how countries lacking generic production capacity would obtain their drugs at lower cost. The TRIPS Council of the WTO was given a year to solve this problem, but was initially blocked by the US, Canada, Japan, and Switzerland, which argued that only time-limited concessions should be made and only for the "big three" diseases of HIV/AIDS, malaria, and tuberculosis (*BRIDGES Weekly Trade News Digest* 6 [19], 22 May, 2002).

The contribution of services to economic growth and wealth has increased rapidly in comparison to the production of goods. Its actual

[4] Doha was the secluded location of the 4th Ministerial meeting of the World Trade Organization, November, 2001.

and potential contribution to trade has also grown (Sinclair 2000). The General Agreement on Trade in Services (GATS) was conceived, and continues to be defended, primarily as a vehicle for the expansion of business opportunities for transnational service corporations (Hilary 2001). The key concern is that GATS will ineluctably lead to increased privatization of such essential public services as health care, education, and water/sanitation. Globally, roughly 30% of all economic activity lies in government (publicly) provided services. Most of these services are essential, meaning there is a guaranteed market for them, at least among those able to pay privately. When there is a crisis of overproduction (too many goods for too few purchasers), or a volatile stock market collapsing after almost two decades of excessive speculation, one might expect corporations with capital to look to formerly provided public services as a safe private investment. There is some evidence this may be occurring: services account for 60% of all foreign direct investment (FDI), "much of which is connected with privatization of state entities" (Corner House Briefing Paper 23, 2001:3).

The pro-GATS argument claims that service liberalization can lead to new private resources to support the public system; can introduce new techniques to health professionals in developing countries; can provide such professionals with advanced training and credentials; and can introduce new and more efficient management techniques (Zarrilli 2002). Several developing countries are liberalizing and privatizing health services, becoming centers of "health tourism" for surrounding countries, and exporting health professionals. But these private resources, whether in the form of health tourism, foreign investment or remittances from professionals working abroad, benefit the wealthy and increase the regressive privatization of domestic health systems. There is a global crisis in the "brain drain" of trained health professionals from developing to developed countries, from poorer to richer developed countries, and from poorer to richer regions of developed countries. Developing countries are estimated to lose over US $500 million in training costs as a result of doctors and nurses who migrate each year to wealthier nations (Frommel 2002). The problem is most acute for African countries, but is also a problem for many Caribbean countries (IDRC 2002), and could be worsened by GATS. Furthermore, the new management techniques that are adopted are primarily those that have been developed by private providers, the majority of which are in the US, a country that has the most inefficient and inequitable health care system of all economically advanced nations.[5]

[5] There is one country where liberalized trade in health services does work: Cuba. Years ago, Cuba set out to become a "world medical power." It is one of the few nations in

To date, 54 WTO members have made commitments to liberalize some health services under GATS (Adlung and Carzaniga 2002). Many of these are developing countries. The number of health-liberalized countries grows to 78 if one includes private health insurance. GATS has a built-in requirement for "progressive liberalization," meaning that countries can only liberalize more, not less. Once a service sector has been liberalized under GATS, there is no cost-free way of reversing it (CCPA 2002). Imagine a poorer country, where most of its former public services are now privately provided, partly a result of earlier structural adjustment programs. Imagine that trade liberalization does eventually promote long-term economic growth, and the country is able to tax such growth so that it has sufficient revenue to increase its provision of public health, education, or sanitary services. If it committed any of these services under GATS, it would have to pay some compensatory damages (in trade concessions, perhaps as fines) should its public programs force private foreign providers out of the domestic market.[6]

Summary and Healthy Public Policy Options

Globalization is not new, but it is taking on new forms. Specifically, liberalized trade in goods, services, and capital is now governed by enforceable trade rules. The dominant discourse on globalization is that of a "tide raising all boats." This "tide" has not been empirically demonstrated except in a few countries, where trade liberalization has lifted all boats but has also made the large ones much larger and the small ones much smaller. Environmentally, the seas supporting the boats, the air filling their sails, and the land on which they dock are all experiencing more severe stress. How globalization more precisely determines peoples' health is affected by a complex set of preexisting political conditions and natural endowments, national policy capacities and resources, and

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the world producing more health professionals than it needs. It has also developed surplus health care facility capacity. Cuban health professionals work abroad, both as acts of international solidarity and as a means of obtaining foreign exchange through remittances. Cuba's high quality health care facilities are "value-adding" to its tourism industry. But Cuba is also unique in having surplus capacity, a fully universal public health care system for all of its citizens and a commercialized health industry that is fully within the public sector.

[6] GATS does offer an exception for "a [government] service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers" (Article 1:3b). This exception is often cited as evidence that concern over privatization is misplaced. This clause, however, may collapse under an eventual challenge, since most countries allow some commercial or competitive provision of virtually all public services (Pollock and Price 2000; CCPA 2002).

publicly provided programs, such as health, education, labor rights and environmental protection. The ability of national governments to self-determine these regulatory policies continues to be constrained by the neoliberal economic prescriptions of the World Bank and the International Monetary Fund, and are increasingly being compromised by World Trade Organization agreements with their "trade creep" effects.

There are, however, several trade policy options that health activists can promote and that might help contemporary globalization's virtuous circle to be realized. These options would:

1. Extend trade agreements' "special and differential" treatment exemptions for developing countries. The European Union, following the lead of many developing countries and development NGOs, is urging that these exemptions be based on the level of economic development within a country rather than on some arbitrary calendar date (*BRIDGES Weekly Trade News Digest*, 6 [39], 14 November, 2002). This small victory was also earned by developing countries at the Doha Ministerial Round of the WTO in 2001, which declared that the WTO should review "all Special and Differential provisions ... with a view to *strengthening them*..." [emphasis added] (WTO Doha Ministerial Declaration 2001). Many developed countries, however, have been reluctant to proceed to do this (*BRIDGES Weekly Trade News Digest*, 6 [34], 8 October, 2002).
2. Ban patenting of life forms, exempt patent protection legislation for poor countries indefinitely, decrease the patent protection period, and permit parallel importing under the TRIPS agreement. These are all positions variously argued by developing and least developed countries, as well as by health, environmental and development NGOs, and many United Nations agencies.
3. Reverse the burden of proof in health and environmental protection cases argued under the exemptions in GATT XX(b), and under the SPS Agreement. Countries claiming that another nation's domestic standards are unnecessarily trade restrictive need to prove that they were *not* imposed for health reasons, and that changing the standard would *not* create a health risk.
4. Institute fines tied to Gross Domestic Product rather than trade sanctions as penalties, since trade sanctions invariably hurt poor countries more than wealthy ones. The WTO has the option to levy fines instead of trade sanctions, but rarely does. Part of the fines could be allocated to global funds for health, education, and social development, allowing the dozens of countries now lagging behind in reaching the Millennium Development Goal targets for infant and

child health, maternal health, gender empowerment, and universal education to start catching up.

5. Impose a "Tobin Tax" on currency exchange transactions (named after the Nobel economist who first proposed the idea). This will dampen excessive currency speculation and, based on 1995 data, would raise about US $150 billion annually. Discussions have already noted that such a tax could be split three ways, with a third going to each of the two national governments whose currencies were being traded, and the remainder to an international development fund.[7]
6. Negotiate an overarching and enforceable rule in all trade agreements that requires, when there is any conflict, multilateral environmental agreements and human rights agreements (including the right to health) shall trump trade agreements. Some 109 countries recognize a right to health in some form in their constitution, and all but a few countries, including the US, have ratified human rights conventions that include the right to health (Blouin, Foster, and Labonte 2002). Several health NGOs have been urging national governments with an interest in health to create a "like-minded group" to pursue negotiation of such an overarching rule within the WTO's ambit. A related reform is inclusion of a special UN rights "clause" in trade enforcement mechanisms, enabling countries to invoke obligations to UN Declarations, Covenants, or Conventions as a shield to any trade-related challenge to a domestic measure that is intended to meet human rights, human development or environmental obligations.
7. Exclude health, education, and other essential services (such as water and sanitation) as commercial services. They are basic essentials to human life and health. Public systems for their provision arose in most countries because private systems proved inadequate and inequitable. Trade treaties, which are intended to promote private economic interests, are no place to negotiate international rules for health, and other essential public services. These require other forms of multilateral agreements freed from commercial economic goals. Canada, France, and other countries are now proposing to create a global cultural diversity treaty that would protect national culture and

[7] Other global taxation schemes include a carbon tax, which would penalize high fossil-fuel using countries such as the US and Canada and provide incentives for reduced consumption. Global taxes, under an appropriately transparent and democratic allocation system perhaps governed by the UN or a new multilateral agency, could permit substantial global wealth redistribution without the many problems currently associated with World Bank and IMF grants or loans, foreign direct investment, official development assistance, or debt forgiveness schemes.

minority language rights, and which would remove cultural products from the WTO ambit (*Globe and Mail,* November 29, 2002; p. B5).

The WTO itself also needs some overhauling. The WTO dispute settlement process is one of its least transparent and least democratic practices. WTO dispute settlement panels should be opened to greater participation from civil society groups, whether in the form of *amicus curiae* ("friends of the court") briefs or actual representation. All proceedings of each panel should be public in the form of web-postings, except for information that may be legally sensitive or confidential. Such panels should also become "joint panels" involving other specialized multilateral or UN organizations (such as UNEP, WHO, ILO) when the trade dispute has obvious crosscutting effects on human health, human rights, and the environment. Panel members should always include representatives from developing countries (this is optional rather than mandatory at the moment), and should be drawn from experts in disciplines other than simply trade law.

In fairness, the WTO has gone some distance in becoming more open about its trade negotiating agendas, initiating more meetings with civil society groups and convening discussions with UN agencies such as the World Health Organization, the International Labour Organization, and the United Nations Environment Program. These UN agencies, however, are still excluded from any of the negotiating sessions of the WTO, and lack any official observer status. For example, the WTO has a Committee on Trade and Environment. The Doha Declaration mandated this Committee to reconcile conflicts between WTO agreements and multilateral environmental agreements, such as the Convention on Biodiversity and the Convention on International Trade in Endangered Species, both of which require trade restrictions against offending countries. But even observer status at the WTO Committee on Trade and Environment by the secretariats responsible for these environmental agreements is still not allowed.

Developing countries are much better organized and more vocal in WTO negotiations than they were in earlier years. Their ability to influence the WTO agenda and decision-making process, however, remains constrained. Nearly half of the least developed country members of the WTO have no representation in Geneva, compared to the presence of over 250 full-time negotiators from the US alone. Many developing countries have only one representative, who lacks the time and expertise to attend all of the different weekly meetings scheduled by the WTO. The push for expanding existing agreements and introducing new issues for negotiation will only further creation of a WTO biased towards the economic interests of developed nations. As several NGOs have argued, "WTO processes

should be designed to suit the capacity of the least powerful members [and] this aim should override concerns about the speed of decision-making" (ActionAid et al. 2001). Among others, this requirement means direct financial assistance from developed to developing countries for WTO participation, reductions in the number of trade-related issues for negotiation at the WTO, fewer meetings, and discontinuing the use of executive body or other subdividing of decision-making away from the General Council.

Finally, existing agreements must continue to be analyzed for their impacts on internationally-agreed basic rights, human development, health and environmental sustainability goals, and changes should be made in WTO agreements when they conflict in any way with the accomplishment of these and other important norms and goals. The WTO, as an institution, should be judged for how it contributes to the accomplishment of these goals and norms, rather than simply on the degree to which it succeeds in promoting trade and investment liberalization.

Conclusion

We live in perhaps the most important historical moment of our species. There is excessive affluence and poverty. Once far-away conflicts and diseases are now imperiling global health and security. We are struggling forward to some system of global governance for our common good. In Western countries, a similar struggle at the national level took place in the nineteenth century. The first laws and the regulatory system in such countries largely served the interests of the capitalist class, at the expense of the workers, women, the poor, the environment. But such laws became the platform around which progressive social struggles created reciprocal responsibilities from both state and market, creating the twentieth century welfare state.

A similar struggle is taking place globally today. Trade agreements are the first truly enforceable international laws we have created. They benefit the capitalist class. They have also become the focus for progressive social movements that are globally demanding that governments abide by their agreements to protect the environment, promote human rights, achieve health for all, and redistribute wealth through universal education and social support systems. The WTO, originally a vehicle primarily wielded for the benefit of the rich countries, is increasingly under siege by developing countries, UN agencies, and NGOs. Some democratic globalizers urge the WTO's abolition. This would be a mistake, for there is no other vehicle where the unequal balance of economic power globally might be subject to enforceable change. The struggles of civil society and developing countries to wrest reforms in the WTO are giving rise to a new system of global

governance for the common good. We cannot say whether these struggles will succeed. But these are global policy options that will work to promote health. We know where these options must be advocated—in our national governments, among our fellow citizens, and in our global institutions.

Annex 1
Open Borders May Improve Economic Efficiency, but at What Price?

Following the introduction of NAFTA (North American Free Trade Agreement), the Mexican government ended its subsidies to corn growers, most of whom were small scale and industrially inefficient. The market was flooded by cheaper US imports, where production remained heavily subsidized, and Mexican corn production fell by half (Wallach and Sforza 1999). Mexican poverty rates rose to over 70%, the minimum wage lost over 75% of its purchasing power, infant mortality rates for the poor increased, and wage inequalities became the most severe of those in Latin America, a region already with the greatest income disparity on the planet (*The Economist* 2000; Barlow 2001). Mexico has since reintroduced production subsidies to farmers, and is in the process of increasing them (*BRIDGES Weekly Trade News Digest* 6 [40], 20 November, 2002). Even with subsidies, Mexican farmers are still much less efficient than US farmers, owing partly to the small size of their farms. But should economic efficiency be the only criterion for determining economic "success"?

Zambia, in return for World Bank and IMF loans, opened its borders in the early 1990s to cheap, often second-hand textile imports. Its domestic manufacturing, inefficient by wealthier industrialized nation standards, could not compete. Within 8 years, 30,000 jobs disappeared and 132 of 140 textile mills closed operations, which the World Bank acknowledges as "unintended and regrettable consequences" of the adjustment process (Jeter 2002). Overall, 40% of manufacturing jobs disappeared in the past decade, and huge numbers of previously employed workers rely on precarious street vending. In the early 1990s, user charges for schools, imposed partly because of the loss of public revenues following collapse of the textile sector, led to increased dropout and illiteracy rates. The current government is now seeking to undo many of these policies, including elimination of user fees for education, lower costs for public health care, a reintroduction of agricultural subsidies and support for domestic industries with a potential for growth. But the task is harder than it might have been before the "open borders" had been imposed.

Many of the low wealth/high health countries (such as China, Costa Rica, Sri Lanka and the "exemplar" Indian state of Kerala) have, or had, relatively equitable income distribution, as well as policies supporting social transfers to meet basic needs, universal education, equitable access to public health and primary health care, and adequate caloric intake (Werner and Sanders 1997). These pro-poor policies are being eroded by trade liberalization. In Kerala, a media-developed Western consumerist culture, alongside tariff reductions, is rejecting locally produced goods for imported luxuries, weakening the local entrepreneurial base. Over time, this will erode the State's ability to tax domestic wealth for

purposes of income redistribution, gender empowerment, maternal/child health and other low wealth/high health outcomes. Economic growth, measured by GDP, may improve, but masks the more important questions: Who gains? Who loses?

Postscript

Since writing this article, two significant developments have transpired. In August 2003, the impasse over TRIPS was temporarily resolved when WTO member nations agreed to waive countries' obligations under TRIPS Article 31(f), which requires production under compulsory licensing to be predominantly for the domestic market. The waiver will last until this article is amended. It also includes several conditions to prevent compulsory licensed drugs from re-entering wealthy country markets. Development groups are concerned that these conditions place undue burdens on poor countries, but there is consensus the August agreement is a positive step. Shortly afterwards, WTO talks in Cancún, Mexico, collapsed when the so-called G-21 of developing countries, led by Brazil, China and India, refused the wording of the Ministerial text that failed to adequately address the trade-distorting agricultural subsidies practiced by the US, Japan and EU member nations. The collapse of these talks can be read as a simultaneous success and failure. The success is the increased strength of organized developing countries attempting to shape trade rules more to their benefit, after a decade of such rules working almost singularly to the advantage of wealthy nations. The failure lies in the apparent commitment of wealthier countries, including the US and the EU, to focus now on bilateral and regional trade agreements where their economic might can more easily overwhelm a diluted developing world opposition.

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