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GLOSSARY

Glossary on the World Trade Organisation and public health: part 2

Ronald Labonte, Matthew Sanger

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Part 1 of this glossary introduced different health and trade arguments, overviewed the history of the World Trade Organisation (WTO), defined key “trade talk” terms, and reviewed three WTO treaties concerned with trade in goods (GATT 1994, the Agreement on Agriculture, and the Agreement on Sanitary and Phytosanitary Measures). Part 2 reviews five more agreements and the growing number of bilateral and regional trade agreements, and concludes with a commentary on different strategies proposed to ensure that health is not compromised by trade liberalisation treaties.

necessary to maintain balance of payments*,² and there are no restrictions on requirements for technology transfer.³ More intrusive are *bilateral investment treaties*, or BITs, which number over 2200⁴ and began their explosive rise after the collapse of talks to create a multilateral agreement on investment (MAI) in the late 1990s.

Agreement on Government Procurement (AGP)

The AGP requires governments to take into account only “commercial considerations” when making purchasing decisions. It specifically bans preferences based on environment, human, or labour rights and requires that bids for government contracts be open to suppliers from all member nations. Currently a plurilateral (optional) agreement, which few developing countries have signed, the 2001 Doha Ministerial Declaration commits members to negotiate a future multilateral agreement on transparency in government procurement. This might aid in preventing large scale cronyism or misuse of public monies by corrupt officials, with negative health impacts because of the loss of funds for public health and social spending. While the Ministerial Declaration states that negotiations “will not restrict the scope for countries to give preferences to domestic supplies and suppliers”, its proponents (primarily *the Quadrilateral Group of Canada, the US, Japan and the European Commission*)[†] view it as a first step in creating a broader multilateral agreement that eventually would prevent national governments from giving preference to domestic suppliers in purchases or contracts. This would remove important policy flexibilities through which governments have combated regional unemployment or social marginalisation of particular groups, strategies with important public health benefits. Similar concerns exist with the *General Agreement on Trade in Services (GATS)*. Services committed under GATS that are contracted by governments are exempt from the most restrictive trade rules (most favoured nation, national treatment, and market access; see glossary part

PUBLIC HEALTH IMPLICATIONS OF AGREEMENTS ON INVESTMENTS, GOVERNMENT PROCUREMENT, AND REGULATORY TRADE BARRIERS

Governments have long used regulations over foreign investment, and their own domestic purchases or issuing of contracts, to fulfil equity oriented policy objectives related to regional development or marginalised groups. These policy flexibilities are increasingly subject to trade treaty restrictions.

Agreement on Trade-Related Investment Measures (TRIMs)

The TRIMs agreement prevents countries from attaching certain performance requirements (such as minimum levels of local content) to approvals of foreign investment. Such requirements have at times been abused by corrupt politicians and officials leading to “crony capitalism”, in which domestic suppliers owned by family members or friends reap most of the performance requirement benefits. Under fairer governance, however, performance requirements have also proved useful in ensuring health promoting employment and income adequacy for marginalised groups or regions. Their removal benefits investors from high income countries much more than it does people living within low and middle income nations.¹ The TRIMs agreement is limited in scope, restricting only government measures that previously required minimum purchases of local goods by the foreign invested company. Countries are also allowed to impose temporary import restrictions on materials the foreign investor may want to bring into the country for manufacturing purchases, if it is

* Balance of payments refers to the difference between the amount of foreign currency coming into a country (including from sales of exports) and the amount leaving (including payments for imports). A large deficit can create serious economic instabilities.

[†] As with any multilateral political process, groups have formed at the WTO embodying different economic, development, and regional interests. The most powerful of these is *the Quad* (Quadrilateral Group).

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1). But it is not clear when a contracted government service becomes a long term concession that may no longer be exempted, for example, water provision in developing countries that is increasingly being managed through privatisation or mixed public-private partnership schemes.⁵

Agreement on Technical Barriers to Trade (TBT)

The TBT applies to technical regulations on goods undertaken for reasons of security, health, or environmental protection. It requires that such regulations not create “unnecessary obstacles to international trade” and that any alternative measure that is “less-trade restrictive” must be implemented.² The public health problem arises in the ambiguity of these terms, and that trade policy and not public health experts interpret them in dispute panels. Many governments now routinely scrutinise proposed health and environmental regulations against the TBT agreement and similar WTO trade treaty obligations, resulting in a loss of public health policy flexibility. At the same time, the TBT agreement precludes governments from imposing import restrictions on like products (goods that are identical or similar to each other) whose process and production methods involve environmental pollution or hazardous workplace conditions that exceed standards in their own country. On the one hand, developing countries fear that, if such restrictions were permitted, it would discriminate against them as they lack pollution control or workplace safety technologies. On the other, this provision has made it easier for transnational corporations to locate manufacturing facilities in countries with weaker environmental and occupational standards, reducing their production costs.

PUBLIC HEALTH IMPLICATIONS OF AGREEMENTS COVERING PROTECTION OF INTELLECTUAL PROPERTY RIGHTS AND TRADE IN SERVICES

The Agreement on Trade-Related Intellectual Property Rights (TRIPS) and GATS have been the subject of intense debate in the public health community for their impacts on access to essential medicines and health care, respectively. The UN Special Rapporteur on the right to health, Paul Hunt, cites both agreements as being in potential conflict with this right.⁶

Agreement on Trade-Related Intellectual Property Rights (TRIPS)

The TRIPS agreement came into force with the 1995 establishment of the WTO. It commits all current and future WTO members to providing a degree of protection for intellectual property (for example, patents, trademarks, and copyrights) comparable to that available in the developed world. TRIPS specifies a minimum period of patent protection of 20 years from the date of application, although with approval processes the actual protected period may be closer to 12 years. TRIPS also provides for a transitional period before developing countries have to comply with all provisions related to patent protection. For some least developed countries, that transition period will be in effect until 2016. For most others it is now expired.

TRIPS provisions on patent protection quickly became controversial because a number of developing countries provided limited or no patent protection for pharmaceutical products and regarded the production of generic copies of patented medicines as an essential element of their public provision of health care. Affordable domestically produced generics are widely regarded as a key ingredient in Brazil’s relative success in controlling AIDS.⁷ The counter argument is that extended patent protection is essential to reward the high investment costs entailed in discovering new drugs. This may be true, although cost estimates are often inflated by

pharmaceutical companies,⁸ much of the research involves public subsidies, and other means to reward such costs without extended patent periods have been argued, for example, advance purchase agreements, special competitions, deeper public funding.

Article XXXI of TRIPS provides for compulsory licensing of patented inventions, but only in “a national emergency or other circumstances of extreme urgency” and under terms that would protect patent holders’ financial interests, making compulsory licensing unaffordable even when permitted. Campaigns by developing country governments and civil society organisations such as Médecins sans Frontières forced the issue on to the agenda of the Doha ministerial conference and resulted in the *Declaration on TRIPS and Public Health*.⁹ The Doha Declaration affirmed “that the [TRIPS] Agreement can and should be interpreted and implemented in a manner supportive of WTO Members’ right to protect public health and, in particular, to promote access to medicines for all”. It further recognised “the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted,” stating that “each [WTO] Member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency”. It was left to the WTO’s General Council to determine how the Declaration would modify countries’ TRIPS obligations. This process took almost two years largely because of resistance from the US pharmaceutical industry, which pressed the US government to argue for the narrowest possible Interpretation of the Declaration. In the end, the General Council decisions did not restrict the application of the Doha Declaration to specific diseases nor restrict its application to specific kinds of emergencies, leaving definitions up to the relevant national government. It also provides some scope for parallel imports—that is, imports of medicines produced under compulsory licences for countries whose own pharmaceutical manufacturing capacity is insufficient or non-existent. Four problems none the less persist:

- (1) The Council decisions do not change the text of the TRIPS treaty but rather are meant to guide its interpretation. They are subject to review and the Decision on parallel imports can be terminated.
- (2) There is no guidance on compensation to a patent holder for obtaining a compulsory license, which could result in unaffordable costs.
- (3) The rules for compulsory licensing and parallel importing are so complex that, in the words of a leader with the India Pharmaceutical Association, “no generic manufacturer would be able or willing to comply with its provisions”.¹⁰ This is one reason why Canada, a year after changing its drug legislation to allow for parallel exporting, has yet to produce a single generic equivalent for this purpose.
- (4) The transition period for India, for years a major source of inexpensive antiretrovirals, ended in 2005, which means it can only produce generic drugs for export if it complies with the Interpretation’s complex protocols.

TRIPS is also controversial for its potential to permit *biopiracy*—the patenting by multinational corporations of life forms originating in poorer nations, including medicinal plants and seeds previously in the public domain. This can affect food security as well as access to traditional remedies. TRIPS allows members to exclude from patentability “plants, animals and essentially biological processes”.² But patentability *must* be extended to microorganisms and

non-biological or microbiological processes, and plant varieties must be protected by patents or a similar sui generis (historical) system of knowledge protection. Some developing countries believe that TRIPS should be amended to better protect indigenous knowledge; this could promote health by increasing wealth for poorer countries, while also protecting biodiversity by rendering it economically profitable to do so. Others urge that all life forms, including microorganisms and microbiological processes, should be banned from patent protection on the basis that such processes are a discovery, not an invention. This latter is the position consistently argued by the *African group*.[‡] Despite their public health implications, neither of these developing country reform measures was addressed in the Doha Declaration on TRIPS, which focused only on drug patent concerns.[§]

A troubling development has been the rise in *TRIPS-plus* agreements. These are *regional or bilateral trade treaties* whose provisions on intellectual property rights afford fewer policy flexibilities than exist under TRIPS. TRIPS-plus agreements typically add new areas of intellectual property rights, limit the granting of compulsory licences, extend patent protections to transgenic life forms, and create dispute settlement rules biased towards the patent holders.¹¹ The public health concern is that such agreements could weaken the small gains made by developing countries at the Doha Ministerial. The USA is reportedly focusing on TRIPS-plus agreements with the expectation that this will eventually force their stronger intellectual property rights into the TRIPS agreement itself.¹³

The GATS agreement

Services have become increasingly important to the economies of high income countries. GATS came into force with the establishment of the WTO, and is designed to reduce barriers to international trade in services. Liberalised trade in services skews benefits to developed countries with advanced and highly competitive service industries and can undermine domestic service industries in poorer countries.¹⁴ The GATS is a broad agreement that covers all types of government action that affects trade in services, regardless of how those services are supplied. Certain GATS rules are top-down and apply generally, to all government measures affecting trade in all service sectors. The most important of these is the *most favoured nation* rule (see glossary part 1).

The most forceful GATS provisions are bottom-up and apply only to those sectors and measures that governments specifically agree to cover. These rules include *national treatment* and *market access* (see glossary part 1). In making commitments to these rules governments can specify how they apply to particular services and government measures. Commitments can be unbound (applying only to current government measures) or bound (covering current and any

[‡] The *Africa group* comprises all African nations, and has taken the lead on TRIPS agreement amendments.

[§] Indeed, the focus on drug patents could be a public health distraction. Attaran points out that poverty in developing countries is a bigger reason for lack of access to essential medicines than drug patents protected under TRIPS.¹² Most essential drugs on the WHO's Model List of Essential Medicines are not patent protected in developing countries, and drug companies often do not pursue such protection in low income countries because of their small market size and lack of ability to pay. Improvements in global health, including curbing of the HIV/AIDS and other infectious disease pandemics, are more likely to arise through reforms in other WTO agreements, such as those covering agricultural subsidies or special and differential treatment, than through reforms in drug patent protection, at least until poorer countries become wealthy enough to matter to the bottom-lines of multinational drug companies.

Table 1 Commitments to liberalise health services²⁴

Service category	Total WTO members	WTO developing country members
Medical and dental services	54	36
Hospital services	44	29
Nursing and midwifery services	29	12
"Other" health services	17	15

future government measures). They can include limitations on the range of services and measures covered, or they can be without limitations. Commitments can be limited to certain ways of providing services, or they can cover all possible ways of providing the service.[¶] This formal flexibility is diminished, however, by intense negotiating pressure to extend the reach of GATS rules with full, bound commitments and minimal limitations.

Several GATS sectors have profound public health implications, notably health, education, and water and sanitation services.^{5 15-17} These service sectors are among those considered basic to the right to health.¹⁸ GATS proponents claim that whether liberalisation in such services produces a net public health gain or loss depends on the domestic regulatory structures put in place to manage its impacts.¹⁹ This may be true. But, referring to health services alone, the 2000 World Health Report cautioned that "few countries (with either high or low income) have developed adequate strategies to regulate the private financing and provision of health services", noting that "the harm caused by market abuses is difficult to remedy after the fact".²⁰

The GATS market access rules also apply to measures known as quantitative restrictions in other WTO agreements. Quantitative restrictions, or QRs are explicit numerical limits, or quotas, on trade measured by quantity or monetary value. GATS prohibits governments from enacting regulations and other measures that have the effect of limiting access to their services markets, the number of service suppliers and their employees, quotas on the value of services provided, or the type of legal entity permitted to provide a service. These rules apply even if the measure is non-discriminatory—that is, even if domestic and foreign provided goods or services are equally affected. This broad definition of QRs may diminish the capacity of governments to contain health costs (by restricting the number of providers) or to ensure equitable regional distribution of health providers.

The principal concern with GATS lies in whether liberalisation commitments will lead to increased private financing and provision of what are presently publicly financed and provided health and other key health determining services.** The GATS agreement, while not the key driver of services privatisation, locks in existing levels and secures and entrenches pro-competitive policies in areas where countries

[¶] The GATS defines four possible ways of providing services, or modes of supply. Each of these can apply to public health services: (1) cross-border delivery of services (such as shipment of laboratory samples or provision of telehealth services); (2) consumption of services abroad (called "health or medical tourism"); (3) commercial presence (foreign investors provide private hospitals, clinics, treatment centres, insurance or facilities management); (4) presence of natural persons (the temporary movement of health professionals from one country to another).

** Or, in the case of many developing countries, services that were publicly financed and provided before structural adjustments imposed by the World Bank and IMF led to their full or partial privatisation.

have made commitments.¹⁷ Increased private financing and provision inevitably follows.†† A country can reverse its GATS commitments only by negotiating trade compensation for any affected countries. Moreover, a top down GATS requirement commits all WTO members to *progressive liberalisation*, where successive negotiating rounds aim to achieve a “progressively higher level of liberalisation” in all service sectors (Article XIX). This reinforces a negotiating dynamic that seeks to continually extend the reach of GATS rules and makes it difficult to maintain limitations or exceptions that shield health care or other health promoting services. The UK Commission for Africa 2005, a high level group created by the British government to advise on industrial world policies towards persisting African health and development crises, cautioned that GATS—like all WTO trade treaties, a commercial agreement aimed at increasing private sector trade—is not an appropriate vehicle through which developing countries should undertake liberalisation of any of their service sectors; “forcing countries to liberalise through trade agreements is the wrong approach to achieving growth and poverty reduction in Africa, and elsewhere”.²¹

Services negotiations intensified in late 2005 as the EU and other developed countries sought increased market access in the developing world. At the 2005 Hong Kong ministerial meeting, WTO members agreed to ambitious goals for agreement by the end of 2006, including significantly extending market access commitments, developing new rules on domestic regulation, and reducing entry restrictions on temporary workers. A plurilateral negotiating process was introduced to induce more extensive market access commitments than have been secured through the bilateral request-offer process. Developing countries made a disproportionate share of GATS commitments in 1995 and often included fewer limitations than those specified by industrialised countries²² (see table 1).

Evocative of the complexity of the agreement, the Canadian government, which steadfastly refuses to commit any of its health services to liberalised trade, unintentionally committed to liberalise trade in health insurance in 1995. Negotiators were apparently unaware that this was covered in the section on financial, rather than health, services. As a result, if Canada extends public insurance into areas where there are presently foreign private providers operating (for example, for dental care or home care) it could face a trade challenge.²³

THREE PERSISTING ISSUES IN THE PUBLIC HEALTH/TRADE AGREEMENT NEXUS

Erosion of the precautionary principle

The precautionary principle has become an important public health concept and tool where there remains lack of scientific certainty over environmental risks of widespread and serious potential health consequences. The essence of this principle is “when in doubt, err on the side of public (or environmental) health”. There are differing opinions on the extent to which this principle has been eroded by trade treaties, notably the SPS agreement and its requirement for a scientific risk assessment of health and environmental regulations, even when such regulations are not trade discriminatory.^{25–27} While WTO dispute panels acknowledge the right of governments to enact regulations that may be more stringent than international standards, the burden of proof for the necessity of such

regulations, and eventual costs of a mistake, rests entirely with the importing country. This allocation of risk contradicts many multilateral environmental agreements, notably the Cartagena Protocol on Biosafety that, in keeping with the precautionary principle, puts the burden of proof on the exporter. Civil society organisations have argued that disputes under the SPS or TBT agreements should similarly reverse the onus so that challenging countries need to prove that a particular regulation was not necessary to achieve its purpose, or could have been substituted with a measure that is less burdensome on trade.

Regulatory chill

Regulatory chill is a term coined to describe the impact of the potential costs of trade disputes on governments’ willingness to introduce new health regulations. An oft cited case involved Guatemala, which backed away from a US complaint on behalf of Gerber Foods that its legislation entrenching the WHO’s International Code on Marketing of Breast-milk Substitutes—which prohibits marketing showing pictures of babies—expropriated Gerber’s intellectual property rights in the form of its “pudgy baby” trademark.²⁸ The dispute was never heard because the potential costs of defending it were beyond Guatemala’s financial reach or priorities. Guatemala amended its legislation to permit imported, but not domestic, infant formula to show healthy babies on its products. The Canadian government similarly let its legislation for plain packaging of tobacco products die after representatives of Phillip Morris International and R J Reynolds Tobacco International argued that it constituted an expropriation of assets (their trademarks), violating *NAFTA* (*North American Free Trade Agreement*) investment, and intellectual property obligations. Again, the dispute was never heard but the costs of fighting the dispute, and possibly losing, were sufficient to “chill” the regulatory option.

Implementation costs

Meeting trade treaty obligations entails direct domestic costs to countries in the form of legislative changes, new regulations and their administration, changes in production to meet international standards, and so on. These costs are disproportionately borne by least developed countries often at the expense of health and social spending.²⁹ WTO member nations consistently promise technical assistance to least developed countries for implementation, but financial levels for this support have been meagre.^{22–30} For “most of the developing and transition economies—some 100 countries—money spent to implement the WTO rules...would be money unproductively invested”.²⁹

REGIONAL AND BILATERAL TRADE AGREEMENTS

WTO trade treaties are not the only ones with public health implications. NAFTA, CAFTA (Central American Free Trade Agreement), and MERCOSUR (a free trade agreement involving Argentina, Brazil, Uruguay, and Paraguay) are among several regional treaties in the Americas. Efforts continue to create an overarching Free Trade Area of the Americas (FTAA). SADC (Southern African Development Community, which is presently negotiating a customs union), ASEAN Free Trade Area (an agreement between 10 South East Asian nations), and the EU (European Union) are examples of other regional agreements. The EU is unique because it is both a *customs union*, in which all goods cross borders tariff free, and a political union with elected representatives, upwards harmonisation of social programmes and transfer payments/loans between richer and poorer regions (although these mechanisms have been undermined by a recent “corporate Europe” orientation). Unlike other commercial trade agreements, the EU is an

†† We set aside an examination of whether increased private financing or provision in health care and other important health determining services is a good or bad thing for the public’s health. What such privatisation does do, however, is limit or remove the ability to cross subsidise the costs of such services from healthy to sick and from rich to poor, rendering whatever mixed system results less fair.

established supranational political system with social, as well as economic, obligations.

Emergence of the WTO in 1995 has not slowed the development of regional or bilateral (two nation) trade agreements. These agreements are invariably more liberalised than those under the WTO, as the GATT 1994 (Article XXIV), which permits the creation of such exclusive agreements between WTO Member nations, requires that they cannot, on average, be more trade restrictive than what existed before the new agreement.

A controversial feature of many of these agreements, particularly those involving the USA (such as NAFTA, CAFTA, and the proposed FTAA) is *investor-state provisions* that allow private corporations to start disputes against governments. NAFTA's *Chapter 11* is the model for such provisions, and resulted in 39 such challenges in its first 10 years of effect,⁵ most of which have yet to be settled. Examples with public health implications include Canada's retreat from plain packaging for cigarettes (described earlier), withdrawal of a ban on a potentially neurotoxic gasoline additive, a fine against a Mexican municipality for stopping creation of a toxic dump site that could pollute its source of drinking water, and an attempt by an American water company to sue a Canadian province for over \$10 billion in lost potential earnings from its ban on bulk water exports.

Similar investor-state provisions are found in most of the proliferating *bilateral investment agreements* (BITs). BITs are often promoted as a means of stimulating foreign direct investment (FDI) that is assumed, in the case of developing countries, to be beneficial to economic growth and poverty reduction, hence health improvement^{††}. In reality, most BITs are intended only to protect existing and subsequent FDI,⁴ and are more restrictive of performance requirements governments might impose on FDI than is the WTO's TRIMs agreement (see above). Many of the scores of BIT cases now in arbitration relate to Latin American water concessions, where private investors are seeking to overturn government regulations on tariffs, taxes, and water quality, with obvious negative health implications. Some foreign mining companies are threatening to use BITs to seek high levels of compensation from the South African government that, to rectify the historical exclusion of the black majority from the country's economy, is changing its domestic legislation on ownership of mineral resources.⁴ BITs generally lack any reference to development goals and dispute tribunals have erred on the side of protecting foreign investors. This effectively minimises any risks they face because of changing sociopolitical, economic, or environmental conditions. Governments intervening to mitigate the health or social costs of changed conditions, or to respond to citizens' needs for better living conditions, could face costly challenges and fines if their actions diminish the profitability of foreign investments.

OPTIONS FOR STRONGER PUBLIC HEALTH CONSIDERATIONS IN WTO AGREEMENTS

Part 1 of this glossary cautioned that the links between liberalisation, growth, and poverty reduction are tenuous, sometimes contradictory, and not universal. There is similarly no easily generalised relation between trade liberalisation, poverty, and health. Moreover, trade rules have been interpreted and applied in unforeseen ways, and with unpredictable health consequences. Developing and least developed countries also continue to face enormous challenges in trade negotiations, as they lack the human

^{††}We emphasise that this an assumption only; evidence suggests that FDI follows economic growth at least as much as leads it. Nor does economic growth invariably reduce poverty.³¹

resources to participate as fully and knowingly in the many ongoing WTO negotiations—to say nothing of the multiplying bilateral and regional trade treaty negotiations.

Of greatest concern is the loss of governments' future policy flexibility, be it in provision of public services, harnessing foreign investment for equity oriented policy objectives, or protecting increasingly scarce environmental resources essential to public health. Over the years, several ideas have been advanced to ensure that trade agreements fulfil the development goals contained in the WTO's unenforceable preamble.

Social clauses

At the first WTO Ministerial Conference in 1996, Oxfam led a number of organised labour and public interest groups in advocating that the WTO strike a Working Group to look at incorporating the International Labour Code within its agreements. Oxfam emphasised the need to move slowly in such incorporation for developing and least developed countries—that is, it recognised their need for *special and differential treatment* (SDT; see glossary part 1). Despite nominal support from the EU and the USA the initiative failed, although it did spark momentum for the idea of social clauses—amendments to WTO agreements permitting use of trade sanctions against countries that failed to live up to core human and labour rights or multilateral environmental agreements. But the idea has met with stiff resistance from the WTO Secretariat and trade negotiators, who argue that it would complicate an already complex set of negotiations. It is also opposed by many developing countries, which fear that such clauses could become a backdoor protectionism for wealthy countries with greater capacity to comply with such clauses.³² As recently as 2004, the AFL-CIO, the largest US labour federation, called on its government to impose economic trade sanctions against China, which it claimed brutally repressed workers' rights to gain a competitive advantage. The US administration rejected the argument, claiming that increased trade with China would be a more effective measure.³³ Both of these claims may have some truth, both mask self interest, and whether workers' rights would be better improved by sanctions or retaining the status quo remains moot.

Conventions outside of commercial trade agreements

The existence of the Framework Convention on Tobacco Control has raised the possibility of creating other health specific conventions outside of the ambit of WTO or other trade treaties. Concern over the long term implications of the GATS agreement on health or health related services, for example, could be mitigated by a convention on international exchanges in these service sectors. Such a convention would privilege the progressive realisation of the right to health, rather than progressive liberalisation in services trade, as both the goal and the standard against which disputes might be resolved. The Canadian government has been promoting creation of such a convention in the area of cultural diversity, with the expectation that a country's domestic policies protecting cultural goods or services would be exempt from trade challenges^{§§}. By promoting conventions such as these national governments can strengthen the international legal and institutional basis for collaboration to promote health, and provide a counterbalance to international trade treaties.

Exemptions for purposes of attaining development goals

There is increased acceptance that developing countries fared less well in the Uruguay Round of negotiations that created

^{§§}How eventual conflicts between the Convention's terms and WTO treaty obligations will be resolved remains uncertain.

the WTO than did the Quad and other wealthier nations. At the same time, the *Millennium Development Goals* (MDGs), a UN adopted set of development targets most of which are directly or indirectly related to health, have gained considerable multilateral policy attention. This has led some analysts to suggest that trade agreements be subordinate to these goals; developing countries would be exempt from trade treaty obligations if they could show its necessity to achieving the MDGs. Specifically, a trade challenge against a developing country would be diverted from the WTO's dispute resolution process to a panel of development experts who would review the challenge in light of the MDGs, or any subsequent set of multilateral development targets. This exemption process would satisfy the criticism of two UN Special Rapporteurs on Globalization and Human Rights who concluded that "it is necessary to move away from approaches that are at hoc and contingent" in dealing with conflicts between trade, human rights, and development.³⁴

CONCLUSION

Many civil society organisations urge the elimination of the WTO, with its intrusive rules that favour commercial trade over domestic health and social policy. Others contend that it should "shrink or sink," its scope scaled back to trade in goods and tariff barriers only, leaving services, investment, and non-tariff barriers (domestic policies and regulations) outside of liberalisation agreements. Still others worry that, as the economies of larger developing countries grow and the developing country majority of WTO members organise more effectively to negotiate around their interests, the organisation may be abandoned by wealthier countries whose own interests can be served better through bilateral or regional trade negotiations. Without some multilateral trade rules, it is feared, economic might will invariably eclipse development right.

Proponents of global trade just as invariably point to its benefits—greater wealth, less poverty, better health. The environmental externalities (resource depletion, increased fossil fuelled production and transport) are acknowledged in passim but resolution for which is left to vaguely worded provisions in only some, not all, trade agreements for "technology transfer." The basic political question of whether free market practices are compatible with human development and public health objectives is rendered into a technical disagreements over the interpretation of this or that exemption or exception, interpretations that inevitably will be left to dispute panels dominated by experts in trade policy and law, not in development or public health.

History offers reason to be cautious about the beneficent claims of global trade. Earlier eras of such trade were linked with the spread of disease leading to public health imposed quarantines on merchant goods. Any slowdown in the movement of goods, however, meant a decline in commercial profit, straining relations between health authorities and the merchant class. Lacking definitive proof of the germ theory of disease, public health leaders eventually retreated to the environmental theory of miasma—one that similarly lacked proof but that posed no threat to commercial interests.³⁵

WHAT ROLE DOES THIS LEAVE FOR PUBLIC HEALTH PROFESSIONALS?

Firstly, exercising the precautionary principle, public health can become more engaged with government trade negotiators in their continuous development of both WTO and regional or bilateral trade agreements. This could be aided by development of a "right to health impact assessment methodology" for trade agreements, as called for by the UN Special Rapporteur on the right to health in his 2004 mission to the WTO.³⁶

Secondly, public health can become more engaged with trade policy experts advising governments on the protection and use of existing policy flexibilities within trade agreements, particularly for purposes of sustaining or improving health. Public health's traditional concerns with infection control, primary health care, food safety, environmental quality, and prevention of chronic disease afford it entry points for advancing particular trade policy options.

Thirdly, public health can support the work of civil society organisations and emergent global health movements, such as the Peoples' Health Movement, which have often undertaken the most trenchant critiques or studies of the health limitations of unfettered global liberalisation.

The challenge is not to eliminate global trade rules, but to achieve a more appropriate balance in which the goals of human development and public health take precedence.

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ADDENDUM

An authors' error occurred in the first part of this glossary (2006;60:655–61). Reference 8 should read **World Trade Organisation**. What is the WTO? http://www.wto.org/english/thewto_e/whatis_e/tif_e/fact1_e.htm#bird (accessed 5 Jul 2006).

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