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International Trade Agreements: Vehicle for Better Public Health?

Jason Sapsin, Ann Marie Kimball, and David Fidler (Moderator)

The United States is behind the curve in thinking about trade and public health. Looking into the future, trade and public health are two of the most important topics of discussion.

This is the tenth anniversary of the World Trade Organization (WTO). The WTO, which is based in Switzerland, is not a United Nations (UN) agency. It has 148 members and 630 staff, and its Director General is Supachai Panitchpakdi of Thailand. The WTO represents a formal break with the UN and the WTO establishes trade agreements, develops policies, and encourages cooperation with other agencies.

Among the health-related agreements promulgated by the WTO are the General Agreement on Tariffs and Trade (GATT) which was signed in 1947; the General Agreement on Trade in Services (GATS) which was signed in 1995; the agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPs) which was signed in 1994; the Agreement on Sanitary and Phytosanitary Measures (SPS) which took effect in 1995; and the Technical Barriers to Trade (TBT) which took effect in 1996.

In regard to trade and health, the universal economic argument is that more trade leads to more wealth, which leads to better health. These can be called the general effects of trade on health, but it is not always clear that this is the way it always happens. It is hard to evaluate simple policy statements on the effects of trade on health. The United States currently believes that trade can do more to boost a developing country’s economy than directing aid and resources to that country.

The specific effects of trade on health include changes in the product mix, changes in the services and providers mix, and changes in willingness to regulate. Products appear where they did not before and new services and providers, which make up 20% of world trade, appear. It should be noted that lawyers are not big on economic theory, but we do understand pesticide regulation, health care issues, and other areas where law affects health. While willingness to regulate has benefits, it can also affect trade negatively.

A common thread is the ability of the WTO to stress participation of markets in member nations. Trade tends to look at public health as inherently limiting market access. The WTO would like to make market access much easier.

In regard to product availability, issues arise when a product, such as alcohol or asbestos, is taxed differently from other products or when a product such as firearms is introduced into a market. When a country seeks access to the WTO, members of the WTO can apply pressure to that country to change its trade policies.

Another area where product availability becomes an issue is food and diet. Reports have stated that changes in behavior when new foods are introduced into a market can result in detrimental health choices. While some would say there are no bad foods, fatty and sugary foods are becoming the next tobacco. Issues over food show the tension between trade, commerce, and public health.

With services and providers, this movement can be seen in health providers and in who controls access to water. An example of the change in willingness to regulate can be seen in the example of Methanex, an additive in gas. California found the additive to be harmful to the environment, but because of the North American Free Trade Agreement (NAFTA), the dis-
Trade became an issue of investor protection instead of public health.

Trade represents the free market approach to reducing poverty and those in favor of this approach argue that we need privatization of markets. This can be seen in the percentages of net capital now moving between countries, where 82% of trade is between private parties and 9% is between public entities.

Privatization is fueled by globalization, international financial institutions, and a push to overcome corruption and inefficiency. Privatization may be a cause for concern, because the private sector may clash over public priorities. For example, if the population is poor, then investors may not be motivated to enter the market. Privatization may also lead to loss of local development.

Water privatization is a good example of what we know about privatization of previously publicly controlled services. In privatization, the focus is on labor productivity, firm growth, and market valuation, but not on public health. This does not produce a good picture of how these efforts play out over time. Physical access may be improved in poor areas, but such access is estimated indirectly. Water piracy may prevent these numbers from reflecting reality. In addition, non-privatized areas usually already have fairly high rates of access to water, so starting where there is no access to water will allow providers to show statistics of success much more easily. Studies have also shown that child mortality has declined in areas where water access is privatized, but over the long term, the public entities offer comparable services and child mortality rates even out.

Trade can disrupt public health practices and influence shifts in public health, especially in the transfer of food. In addition, the commoditization of goods does not “feel good.” It feels disturbing to put control of water access in private hands. Barriers to increased awareness of the effects of trade on public health are institutional resistance, lack of resources and coordination, and lack of balanced advocacy.

The World Health Organization (WHO) recommends training, compliance counseling for SBT and TBT, more interaction between public health and trade, and health impact assessments. It should be noted that, in their recent report on the future of the WTO, the WTO did not mention the WHO, whose offices are just down the street from the WTO. It is not enough to say trade is a problem for public health.

The WHO thinks trade is a problem, but we cannot ignore trade. Trade is not going away. How it affects public health will depend on the participation of public health officials in the debate.

Ann Marie Kimball

Public health’s core mission is to protect populations from infectious diseases. However, despite the enormous range of global trade, there is no working group on health at the World Trade Organization (WTO). It should be noted that trade is good for some regions, especially the Asian Pacific region, where even non-market economies such as China and Vietnam have seen positive results from trade. Therefore, when discussing the effects of trade on public health, we need to specify the effects region by region.

The world population has reached unprecedented levels, but the world urban population is mostly centered in developing countries. Access to water and sanitation in those areas is uneven, with about 1 billion people short on water and 2 billion people short on sanitation.

Uncontrolled urbanization plus globalization of travel and trade can equal huge risks. This can be seen in the agricultural poultry industry. Pathogenic influenza led to the deaths of millions of chickens and, as a result, millions of dollars. The intensification of poultry agriculture in poor sanitary environments can lead to high risks because disease in those areas is difficult to control. In a pandemic, the primary level of microbial traffic is at the point of emergence. The secondary level is by local extension, and the tertiary level is in geographically dispersed clusters.

Trade-related infections emerge coincidently with ramping up production for global market demands, increased efficiencies mandated by tariffs, or innovations in product manufacturing. Reducing tariffs increases market access and increases competition. In the case of HIV/AIDS, transmission was amplified through global trade. In addition, a description of infection can cause disruption in travel and trade, which can be extremely expensive.

Poultry exports from East Asia increased 25 fold in the decade preceding 2000. This was a result of a need for high-protein food, and much of the poultry was eaten fresh in the region. Now there is a need to restructure the poultry industry, but we do not have the metrics to measure successful restructuring.

There is now active surveillance in place for avian influenza. While there is a high human mortality rate for avian influenza, the disease does not transfer from human to human very well. The threshold of this pandemic is not yet known. However, even in the best situation, the risks associated with avian influenza are high.

Other examples of diseases being transmitted as a result of ramping up, consolidation, advances in pro-
cessing, and pooling of biological materials in processing include HIV/AIDS in the Factor VII global market, *E. coli* O157:H7 in beef, and bovine spongiform encephalitis (BSE or "mad cow"), in beef. BSE transmission may have been related to changes in rendering and increased efficiencies that were needed as a result of GATT pressure on beef tariffs.

Among the "tools of the trade" are agreements such as the General Agreement on Tariffs and Trade (GATT), the Technical Barriers to Trade (TBT), and the Agreement on Sanitary and Phytosanitary Measures (SPS), which have interactions with emergence paradigms. The GATT's commitment to tariff reduction may lead to enhanced efficiency. In addition, both TBT and SPS mandate notification of urgent trade restrictions, and human health concerns are the leading rationale for notification in both cases. In the case of BSE, notification practically stopped beef export from Great Britain. The notification may be a smokescreen, though, given the high number of notifications each year. Also, the World Health Organization (WHO) is not given access to the information in the notifications.

Can public health pull the brakes on the global express? Local systems for isolation, quarantine, and epidemiological investigation and control are weak. Other options are recall of products and trade restrictions, but these are in doubt. While the WTO already has a committee on the environment, the WTO also needs a committee on health. Remedies for microbial traffic can start with national and local public health agencies and then move to the WHO and WTO.

In the new International Health Regulations (IHR), which create a positive obligation to create capacity within countries and a mechanism for declaring public health emergencies, there is no mention of trade or contact with the WTO. The regulations, which will be implemented in 2007, will seek to enfranchise poor countries to establish public health infrastructures.

The future of world trade still raises questions. Will the mandates for "safety nets" in countries in the IHR be realized? Can these measures mitigate risks? Will product alerts through urgent measures reach the WHO in a timely manner? Can the WTO and WHO work together on secondary prevention? Currently, there is little operational discussion between the two parties. Finally, will it take a pandemic to get a standing committee on health at the WTO? Eventually, both sides, trade and public health, must come together.

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*David P. Fidler*

Over the past ten years, the World Trade Organization (WTO) dominated the relationship between public health and international trade. But what does the next decade portend? Analyzing this question involves looking at three areas: (1) potential developments within the WTO; (2) the proliferation of bilateral and regional trade agreements; and (3) the implementation of the new International Health Regulations (IHR).

**Potential developments within the WTO.** In the next decade, the trade-health relationship is intertwined with the fate of the Doha Development Agenda, the failure of which may mean that poverty and its attendant public health problems will become even more entrenched. Thus, the Doha Development Agenda itself is important from a public health perspective.

In terms of specific WTO agreements, potential developments with the agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPs), the Sanitary and Phytosanitary Measures (SPS) agreement, and the General Agreement on Trade in Services (GATS) may have the most importance in the next ten years. Concerning intellectual property, one development to monitor is whether any countries take advantage of the third-party compulsory licensing mechanism established in 2003 (the so-called Agreement of the Implementation of Paragraph 6 of the Doha Declaration). To date, no countries have utilized this mechanism, even for anti-retrovirals. Another area to watch is what impact the WHO Commission on Intellectual Property Rights, Innovation, and Public Health will have on the controversies surrounding intellectual property rights and public health.

Certain developments concerning the SPS Agreement might bear watching. In particular, the upcoming decision expected in the *EC - Biotech* case, filed by the U.S. against the EC's regulations on genetically modified organisms, may be seminal for how the SPS Agreement is interpreted and applied in the future.

Finally, the potential liberalization of trade in services under GATS is important. Negotiations on such liberalization continue as part of the Doha Development Agenda, and how negotiations deal with health-related services will be critical. In addition, new case law under GATS may also be forthcoming in the next ten years. The recent decision in the *US - Gambling* case, although not involving public health, has implications for public health, especially with respect to specific commitments on market access.

**Proliferation of regional and bilateral trade agreements.** The "next wave" in the trade-public health
relationship may be affected most by the proliferation of regional and bilateral trade agreements. Instead of a multilateral system, a complicated "spaghetti bowl" of preferential trading arrangements is emerging. The spaghetti bowl also includes approximately 2,000 bilateral investment treaties that regulate foreign direct investment.

How does this spaghetti bowl of regional and bilateral agreements affect public health? So much attention has been focused on the WTO that, with some exceptions, the public health community has been slow to appreciate the proliferation of regional and bilateral agreements represents. The impact on public health of these regional and bilateral agreements could be significant in each area of the trade-public health relationship, including intellectual property rights, SPS measures, services, and the manner in which disputes are settled.

The Central American Free Trade Agreement (CAFTA) provides an illustration. A number of public health experts have argued that CAFTA represents a threat to public health in the CAFTA nations (United States, Costa Rica, Dominican Republic, El Salvador, Guatemala, Honduras, and Nicaragua). Analytically, assessment of the impact of agreements such as CAFTA on public health could start by evaluating their rules against relevant WTO agreements because public health’s familiarity with the WTO provides a baseline for thinking about what’s in the spaghetti bowl.

Crudely, CAFTA’s rules on trade in goods, SPS measures, technical barriers to trade, and general exceptions for measures that protect human health more or less track what’s in WTO agreements. CAFTA differs from WTO rules in three areas: protection of intellectual property rights, trade in services, and dispute settlement. CAFTA contains provisions that require greater protection of intellectual property rights than TRIPS. In terms of services, CAFTA differs from GATS in that it applies market access and national treatment obligations on CAFTA states parties, except for non-conforming measures the parties list in an annex. This means that CAFTA’s liberalization of trade in services is more aggressive than GATS. Finally, CAFTA creates its own dispute settlement mechanism that could be used instead of the WTO. This creates another dispute settlement system public health experts have to monitor for decisions that may impact health policy.

This focus on CAFTA suggests that the implications of regional and bilateral agreements are complex and cannot be summarized by “sound bites.” The bottom line is, however, that these regional and bilateral agreements constitute an important topic on which more public health attention is needed.

The New International Health Regulations (IHR).

The new IHR, adopted in May 2005, will affect the trade-health relationship. The new IHR attempt to balance trade and health interests as did the old IHR, but the new IHR are radically different and more demanding. What needs to be watched in the next decade is whether the radical transformation the new IHR represents is actually implemented in a way that maximizes synergies between public health and trade.

The past decade was one in which public health had to adjust to the WTO. The way in which the WTO altered the relationship between trade and public health had the ironic effect of making public health more politically important than it had been in the past. The next decade will be different as public health will have to continue to deal with the WTO but also swim in the spaghetti bowl of regional and bilateral agreements. The new IHR adds another regime to the mix in terms of the future relationship between trade and public health.

The Holy Grail of this relationship has, of course, been policy coherency between trade and public health. Achieving such coherency will prove difficult; and public health still does not have the muscle that trade possesses, placing a greater burden on public health to understand, influence, and manage international trade agreements in a way that shapes them, as much as possible, into vehicles for better public health.