CHAPTER 10

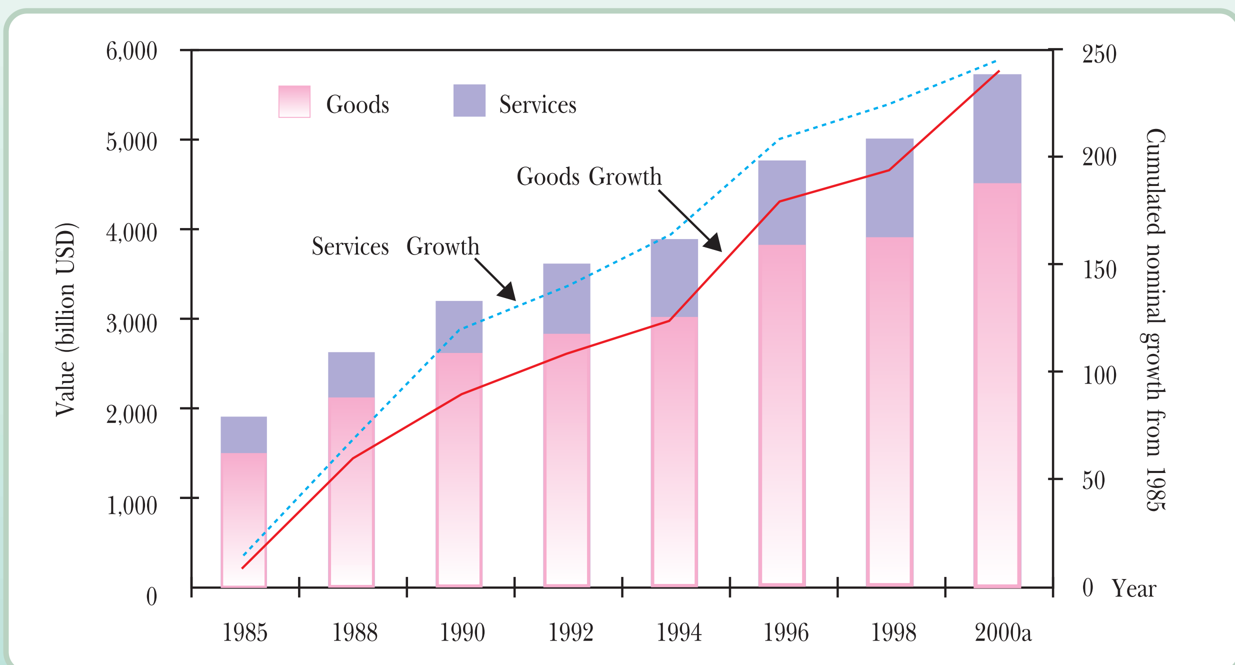
Health Systems and International Trade

The implication of international trade on health have been recognized for centuries. For example the path of the Black Death (from Plaque) followed international trading routes in the 14th century. The first international Sanitary Conference in Paris in 1851 was also catalysed by the overruns of cholera in Europe since 1830.

International Health Organizations were created mainly based on the purposes of controlling infectious diseases spreaded through international trade/travel. These are, for example, Pan American Sanitary Bureau (1902), Health Organization of the League of Nations (1919), and finally the WHO (1948).

In the past few decades there was a **strong** and rapid trend toward globalization of trade. This was accomplished through several international trade agreements supported by globalization of world economy, scientific advance, and the creation of vast communication webs. The size of the international trade in 2000 was estimated at $US 7 trillion. About 20% of this ($US1,400 billion) are trade in services. Global size of health services sector is estimated at $US 3,000 billion, mainly internal market, no definite figure for international trade, however. The figure for Thailand was around $US 5 billion or 0.17 percent. The size of global pharmaceutical trade was around $US 400 billion. Thailand shared around $US 1 billion, or 0.25 percent. Twenty-five countries accounted for more than 80% of international trade (Figure 10.1).

Figure 10.1 Growth of trade among OECD countries 1985-2000

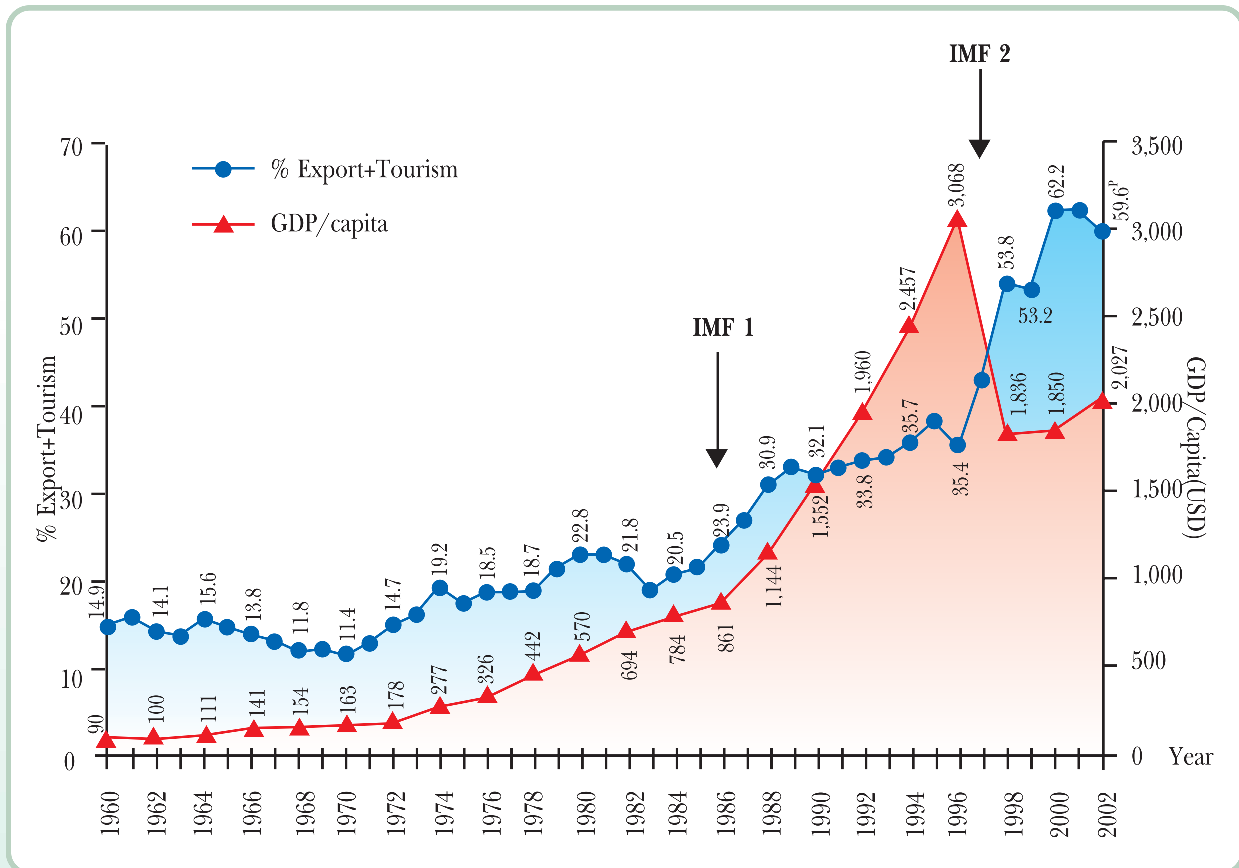


Source: OECD-Eurostat, OECD Statistics on International trade in services, 2001. IMF, Balance of Payments Statistics Yearbook, 2000.

Note: a 2000 OECD estimates

International trade is accounting for an increasing share of GDP in both developed and developing countries. For example, more than 60% of the Thai GDP in 2001 was contributed by international trade (Figure 10.2).

Figure 10.2 Percent of Export and Tourism in the GDP, Thailand 1960-2002



Source: National Economic and Social Development Board.

Note: P = preliminary figure.

1. World Trade Organization (WTO)

1.1 Origin of WTO

The devastating protectionist policies of many countries in early 1930's, which led to the collapse of the world economy, was the impetus for 23 countries to sign a treaty, in 1947, establishing **GATT** (the General Agreement on Tariffs and Trade). The GATT's objective was to promote and regulate the liberalization of international trade through "**rounds**" of **trade negotiations.**

The eighth round of Multilateral Trade Negotiations, held in Uruguay in 1986 (known as Uruguay Round) and concluded in April 1994 by the signing of Marrakech Agreements, had led to the establishment of a new **permanent** international trade organization known as the **WTO** (the World Trade Organization).

The first seven round of trade negotiations dealt mainly with the issue of tariff. In the 8th round, additional issues of intellectual properties and trade in services was also negotiated.

1.2 Teeth and Claws of WTO (Figure 10.3)

The instrument under WTO consists of multilateral agreements that become **binding** upon Member States when **they join WTO**, and pleurilateral agreements that are **optional**. The legal framework constituting the WTO has been compared to a tricycle (Figure 10.4):

"A driver (WTO), two large wheels (13 MTAs-Multilateral Agreements on Trade in Goods and GATS-General Agreement on Trade in Services) and a smaller one (TRIPS-Agreement on Trade Related Aspects of Intellectual Property Rights)".

Figure 10.3 Teeth and Claws of WTO

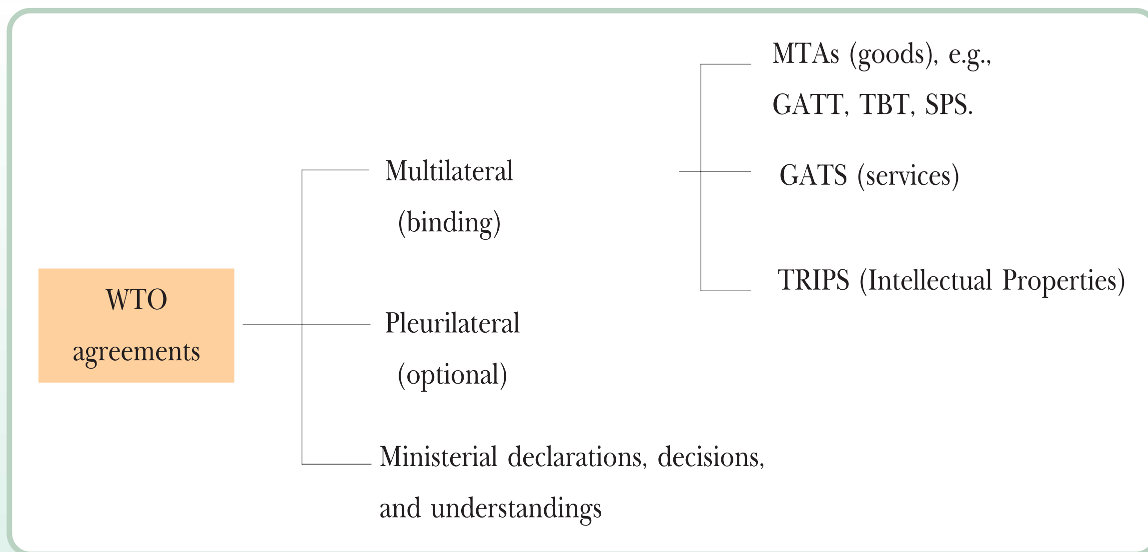
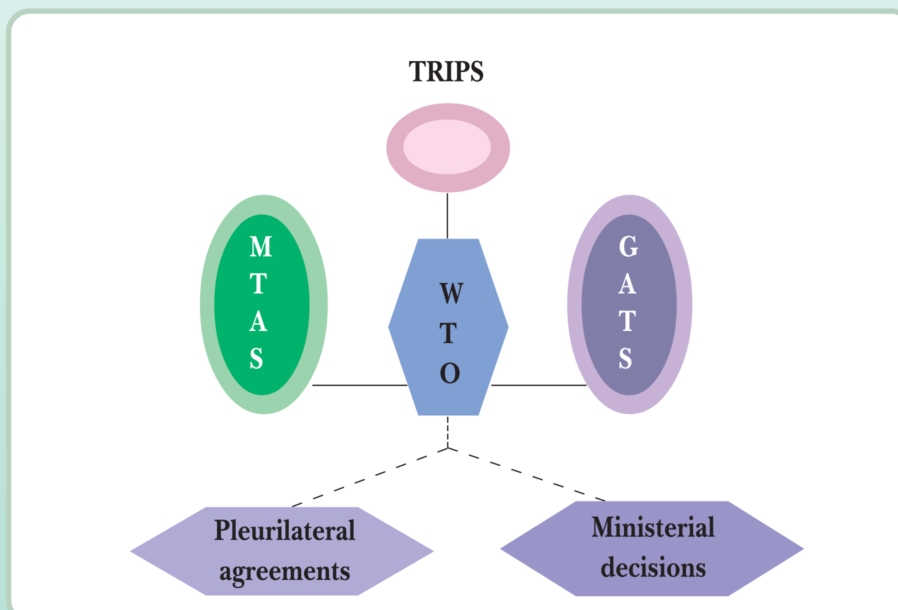


Figure 10.4 WTO frameworks (Tricycles)



1.3 Functions, structures and members of WTO (Figure 10.5)

1.3.1 Functions WTO has 5 main functions:

(1) Administers and implements its trade instruments.

(2) Conduct **multilateral trade negotiations**

(3) Oversees national trade policies.

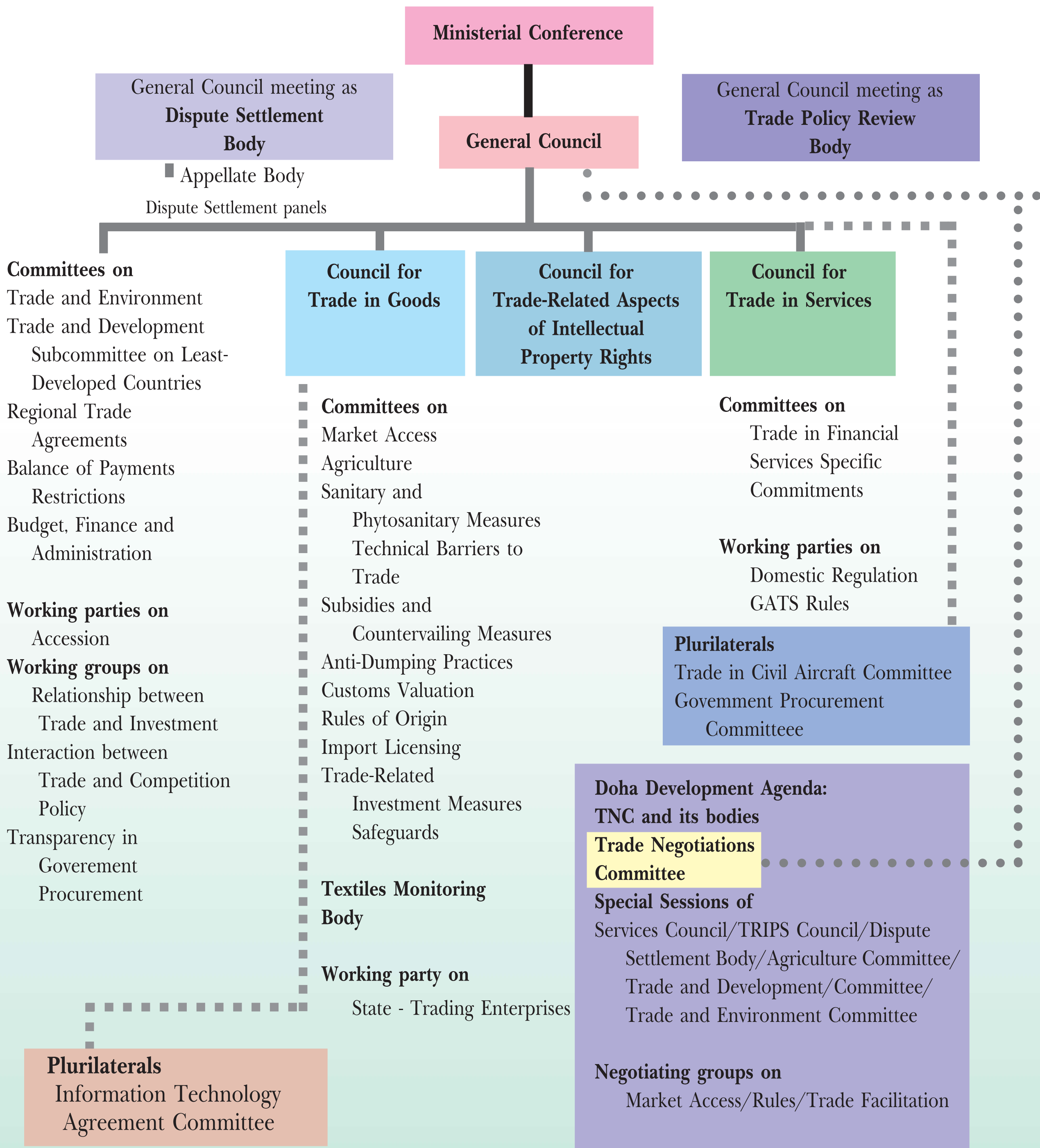
(4) **Resolves trade disputes** among its members

(5) Impose **trade sanctions**.

1.3.2 Structures (Figure 10.5)

WTO's highest authority is the Ministerial Conference, which meets every two years. The day-to-day work of WTO falls upon the General Council and the Secretariat.

Figure 10.5 Structure of WTO



Key

Reporting to General Council (or a subsidiary)

Reporting to Dispute Settlement Body

Plurilateral committees inform the General Council or Goods Council of their activities, although these agreements are not signed by all WTO members

Trade Negotiations Committee reports to General Council

The General Council also meets as the Trade Policy Review Body and Dispute Settlement Body

ที่มา: www.wto.org.

1.3.3 Members

As of December 2004, WTO has 148 members and 31 observers. Thailand is one of the founding members of WTO since its inception in 1995.

1.4 General principles of WTO

1.4.1 MFN (Most - Favoured Nation)

Members must accord all of the treatments to one member no less favourable than they accord to other members.

1.4.2 National treatment

Members must treat investors from other member countries no less favourable than their nationals.

1.4.3 Transparency

Trade related information must be made readily available to all.

1.4.4 Mutual Recognition

Mutual recognition of market authorization, degrees, curricula, and licenses.

1.4.5 Progressive liberalization and preferential treatment for developing countries

Trade liberalization should be gradually and progressively implemented. Possible negative implications to developing countries should be avoided.

1.4.6 Domestic regulation

Domestic regulations must be reformed to go along with international trade agreements.

1.5 WTO and public health

1.5.1 Protection of Health

Multilateral agreements under WTO usually contain provisions for **the protection of human health and safety**. For example Articles XX (b) under the General Exceptions section of the GATT allows **"each contracting party to set its human, animal or plant life or health standards"**. However, these standards must not represent an **"unjustifiable discrimination or a disguised restriction on international trade"**.

1.5.2 Health related WTO agreements

Many of the WTO agreements have health implications. For example, GATT liberalize the trade on alcohol and tobacco which may result in increase consumption and health risk. However, there are four WTO agreements, which have high direct health impact, i.e.,

(1) MTAs (Trade in goods)

(1.1) TBT (Agreement on Technical Barriers to Trade)

(1.2) SPS (Agreement on Sanitary and Phyto-Sanitary Standard)

(2) GATS (Trade in services)

(3) TRIPS (Intellectual properties)

2. MTAs and Health-SPS and TBT

When GATT reduces the tariff barrier to international trade, non-tariff barriers became real concern. These are dealt with mainly under TBT and SPS.

The WTO Agreements on Sanitary and Phyto-sanitary Measures (SPS) was drawn up to ensure that countries apply measures to protect human and animal health (Sanitary measures) and plant health (phyto-sanitary measures) **based on the assessment of risk**, or on the other words, **based on science**. The SPS Agreement incorporate, therefore, safety aspects of foods in trade.

The Agreement on Technical Barriers to Trade (the TBT Agreement). It covers all technical requirements and standards (applied to all commodities), such as labeling, that are not covered by the SPS Agreement.

As a natural consequence, the SPS Agreement recognized the standards and related texts of the **Codex Alimentarius Commission** (WHO and FAO) as international points of reference.

Thailand is one of the world top food exporter. Thus the active involvement in the SPS negotiation and the CODEX mechanisms has been a high priority. This is a collaborative effort among several ministries, i.e., Ministry of Commerce, Ministry of Industry, Ministry of Agriculture and Cooperatives, and Ministry of Public Health. The involvement not only ensure the fair treatment for Thai products, but also improve the standard of food products for local consumption.

3. Liberalization of Trade in Health Services - GATS

Initially, many countries, especially the developing ones, were reluctant to include trade in services in the Uruguay Round Negotiations, the reason being that international trade in services is significantly different from that in goods. The latter involves trans-border transactions, while the former could call for the exercise of the right of establishment, which would have implications for development strategy, resource mobilization, social objective, etc.

Thus the principle put forward as the main objective of GATS was to ensure that **priority be given to developmental issues,** and that **national regulations remain supreme.** In effect, the **Agreement allows Member Countries to select their service sectors for opening to international competition in the light of their national development strategy.**

3.1 Modes of international trade in services

In contrast to trade in goods, which mainly deal with cross border trade, trade in services encompass 4 main modes (Figure 10.6).

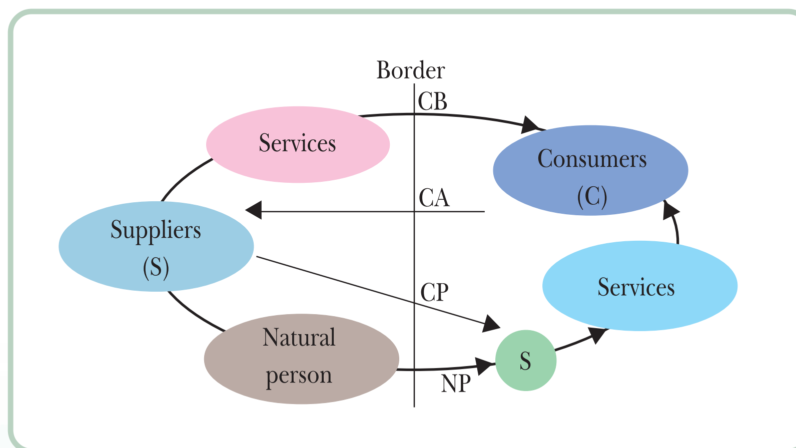
3.1.1 Cross Border Trade (CB), e.g., Telemedicine, teleconference and teleeducation, subscription of journals and database on Internet.

3.1.2 Consumption Abroad (CA), e.g., Travelling abroad to seek high technology or cheaper health services.

3.1.3 Commercial Presence (CP) i.e., Foreign investment in hospital operation, medical and dental services, and management of health care.

3.1.4 Movement of Natural Person (NP), e.g., Emigration of doctors from developing to developed countries, and import of specialist from developed countries into the facilities invested by foreign capital in the developing countries.

Figure 10.6 Mode of international trade in services



3.2 Services under GATS

Twelve services categories are included in GATS. At least five of which are directly related to health, i.e., Business, Education, Distribution, Finance, and Health service sectors. The professional services under Business services deal with recognition and movement of health professions. The Education services relate mainly to training and education of health professions. The distribution services relate to pharmaceutical distribution, i.e., drug stores. The Financial services include Health Insurance. The Health services include hospital services, medical and dental services, diagnostic services, and management of health services facilities.

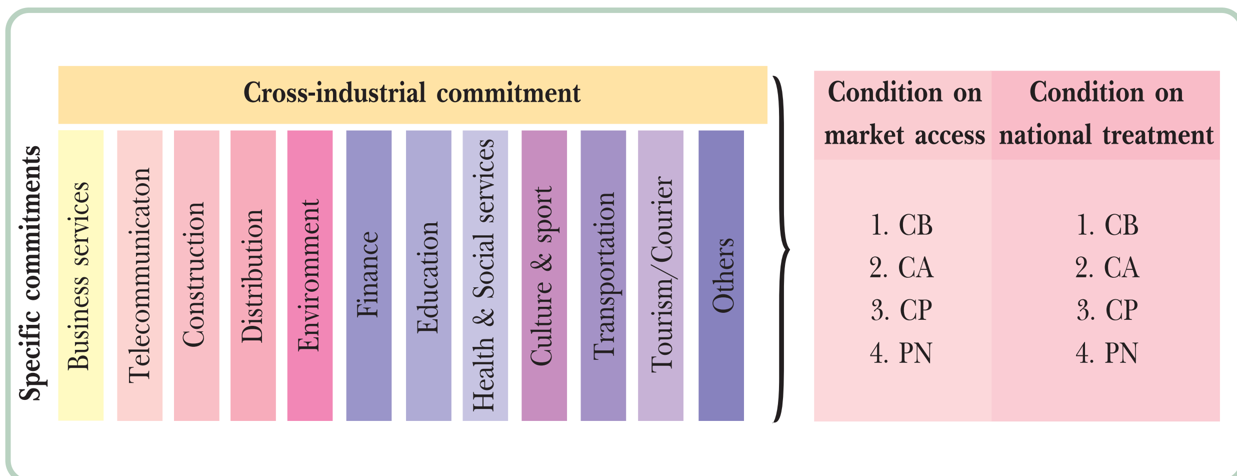
3.3 Member commitments (Figure 10.7): These are **voluntary** commitments proposed by each member on **conditions** for Market access and National treatment. Members may modify or withdraw any commitments in the schedule at any time after three years have elapsed and negotiations on compensation to affected countries.

3.3.1 The General commitments (Cross-Industrial): These voluntary commitment apply to every sector of trade in services.

3.3.2 The Specific Commitment: GATS Agreement allows Members to choose the service sectors and activities to which Members wish to apply the market access (called the **"market access commitments"**). Members can indicate it in the schedule of specific commitment and place conditions and limitations on it (called the "market access limitation).

It was found that Thailand committed to GATS within its legal framework. This means that Thailand does not have to amend its legislation to comply to its commitment to GATS. However, it has to be prudent in extending the commitment to the full extent of its legal framework. This is because in case that future situation require reduction in the degree of trade liberalization, amendment of legal framework need prior negotiation with and compensation to member countries. Emergency safeguard measures (ESM) should be negotiated for, before expanding its GATS commitment.

Figure 10.7 Member's commitments



3.4 Potential health implications

International trade in health services can generate financial resources, thus improving the infrastructure and upgrading technology capacity.

The Thai experiences showed that international trade in services may have negative impact on the equitable distribution of health personnel. The opening of financial market by establishing the Bangkok International Banking Facilities (BIBF) in 1993, had resulted in mushrooming of the urban private hospitals and internal brain drain of human resources (see Chapter 9).

The government is now negotiating the free trade Agreement with many countries. One of the issue is the expansion of health service market with Japan. It was estimated that if the same trend of expansion of international health service trade continues, there will be a requirement of 910-1372 medical doctors in 2015.

4. Protection of Intellectual Properties-TRIPS

4.1 Rationale and Scope of TRIPS

Since large industries such as computer software manufacturers, pharmaceutical companies, and agri-food enterprises depend on protection of intellectual property in order to ensure innovation, it was argued that the TRIPS Agreement was a crucial foundation for the global trading order.

This Agreement is annexed to the WTO Agreement. Its main aim is to strengthen and harmonize certain aspects of the protection of intellectual property at the global level. It covers both categories of intellectual property: **industrial property** (trademarks, patents, geographical denominations, industrial designs and models, and unpatented know-how), and **literary and artistic property** (copyright and neighbouring rights)

4.2 Main Requirements of TRIPS

4.2.1 The Agreement requires Members to grant **patent** for any invention, whether **product or process**, in all fields of technology for **20 years**, and without discrimination as to place of invention or origin of the product. They **may** also grant **patent for microorganisms or non-biological and microbiological**

processes. Member Countries are allowed to make certain exclusions, such as plants and animals, diagnostic, therapeutic and surgical methods for the treatment of humans and animals, and essentially biological processes for the protection of plants and animals. The Thai patent act has already included all these exclusions.

4.2.2 The Agreement makes provisions for the use of **patent without authorization of the patent holder**, with a number of conditions and limitations. These are included in the mechanism of parallel import, government use and compulsory licensing.

4.2.3 In the dispute on the infringement of process patent, the defendant should take **responsibility** for proving that the process is different from the patented one.

4.2.4 Members are given **transitional period** for implementation of the Agreement, one year for industrialized countries, five or ten years for developing countries, and eleven years (extendable) for least developed countries. However, Members must provide exclusive marketing rights for five years to the applicant for the pharmaceutical product patent even before the expiry of the transitional period.

Due to trade pressures from major trading countries, Thailand amended its patent act, which comply with TRIPs since 1992, eight years before the TRIPs dead line.

4.3 Potential health implications

The impact of the TRIPS Agreement on a particular country will depended on the market structure, the situation of the local pharmaceutical industry, legal environment, its own national drug policy and other factors which make every country a special case. However, different views still remain on the impact of the Agreement:

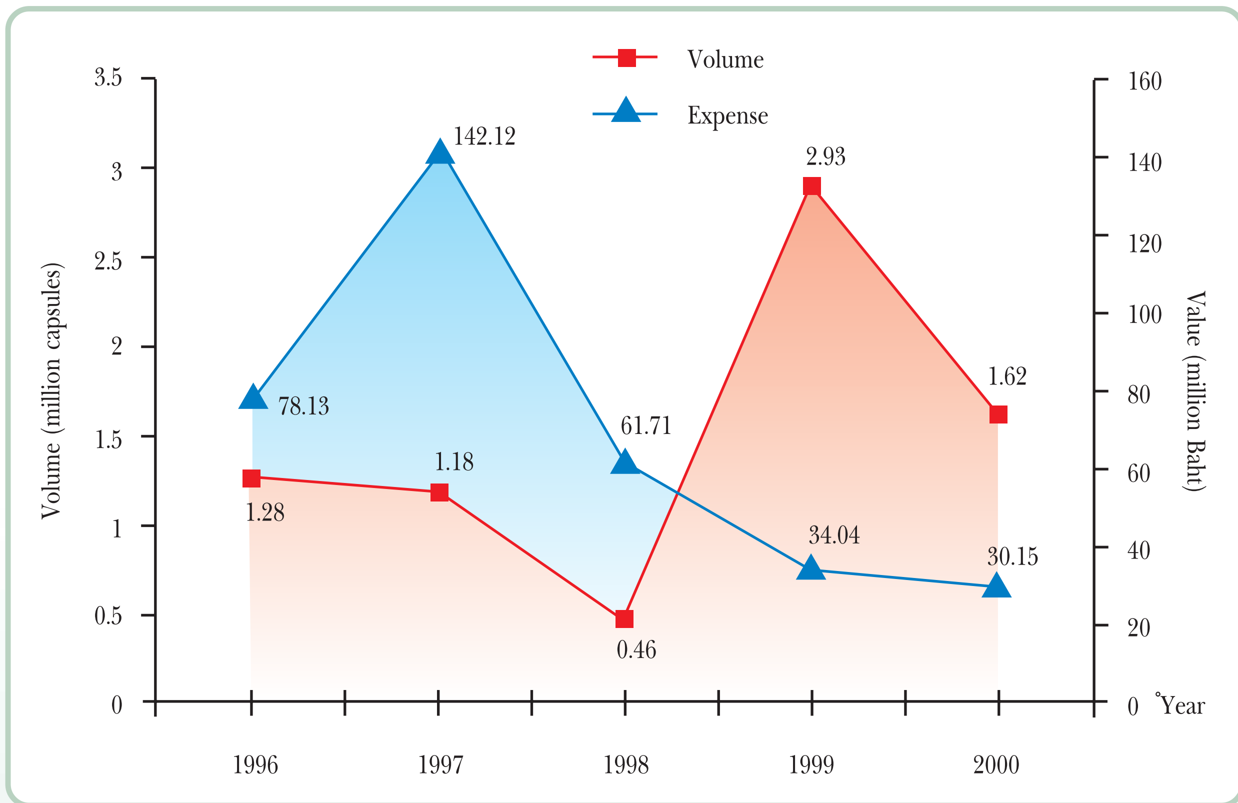
4.3.1 Innovation: Patent protection definitely promote innovations in drugs and medical technologies. However, this may not be true for diseases that are predominantly found in developing countries.

4.3.2 Cost escalation: Many studies on the subject suggest that prices of patented drugs and the amount of patent royalties will increase. There could be real concentration of drug production in industrialized countries rather than transferring technology or foreign investment directly developing countries. The new WTO patent system will not increase research and development in developing countries. Evidence in Thailand do prove these implications. The price of Fluconazole, an anti-fungal drugs, reduced ten times after expiry of market exclusivity (Figure 10.8).

4.3.3 Transfer of Technology: Some scholars argue that protection of pharmaceuticals will lead to an increase in the flow of technology transfer. There will be an increase in the magnitude of direct foreign investments, which will be to the benefit of the developing countries. The increase in resources devoted to research and development by local pharmaceutical companies in developing countries will lead to the development of new drugs suited to their own situations as well as better quality drug products and to end the "brain-drain" in developing countries. Research in Thailand found no increase in technology transfer after amendment of patent act.

4.3.4 Local Production: Patent protection may have both negative impact on local generic drug industry. At the same time it may also promote more local patented products.

Figure 10.8 Expense and Volume of Fluconazole in Thailand, 1996-2000



Source: Drug Control Division, FDA, MoPH.

4.4 Expansion of Intellectual Properties Protection under Bilateral Trade Agreements

The bilateral Free Trade Agreements that the government are negotiating with some developed countries especially the USA and Japan, is likely to result in expansion of Intellectual Properties Protection, both patents and copyrights. For example, extension of patent life beyond 20 years, more conditions to limit use of compulsory licensing, and data exclusivity to delay generic drug registration. If these FTAs are signed with the above-mentioned conditions, it will affect the drug prices and accessibility to essential drugs.

5. Conclusion

The advent of the WTO has brought with it a new concept of international trade law, framed according to universal principles. The full integration of environmental and social matters represents the next generation of trade agreements. This inevitable shift in trade thinking is “already knocking at the door”. Strengthening provisions protecting public health in global trade agreements should not be used indiscriminately, for unadulterated trade protectionism. The public health community needs to understand the health ramifications of global trade agreements, and must concentrate on getting its own facts correct, so that public health is not “naively” used for other political ends, for example to justify unwarranted economic

protectionism. In areas such as tobacco and other hazardous commodities, food safety, liberalization of trade in services, and patent protection of pharmaceuticals the health sector has a clear role to play. However, before it advocates for certain policies the health fraternity needs to get its own house in order. Healthy-trade policies, for example a global war on tobacco, which are guaranteed to make an impact on the future burden of disease, are a means of reaching a more sustainable form of globalization.

In this regard, it is the responsibility of the health sector to ensure that its arguments are technically sound when advocating for protection of public health. Excessive measures, which impede trade unnecessarily should not be implemented. Health and trade policies should be aligned at global and national levels. The health sector should be adequately informed about the implications of global trade agreements. Finally the globalization and rapid transformation of the world's trade and financial system should not been seen as an end in itself, but rather as an economic tool which should be adapted so that marginalised populations and broader social policies are not neglected.

Although trade liberalization and economic globalization are often asserted as "inevitable and desirable", they present formidable challenges and uncertainties in the promotion of 'health' in many countries.

Coordinated and determined advocacy by health workers at national, regional and global levels could and should play a much greater role in mobilizing public and political support in this respect.

Several immediate challenges lie ahead of them:

(1) To deal with national reform process now taking place at the country level to conform to WTO agreements.

(2) Be ready for new round of trade negotiations, bilateral and multilateral.

(3) To rapidly develop their institutional capacity on international health.

(4) To develop strategies to alleviate any untowards health imports from international trade.

It is recommended that a comprehensive approach is required to strengthen the national capacity in order to benefit from the international trade. A conceptual framework was proposed (Figure 10.9). In Thailand, multi-sectoral mechanism are created for the development of Thai position in several international trade negotiation (Figure 10.10).

Figure 10.9 Conceptual framework for capacity strengthening

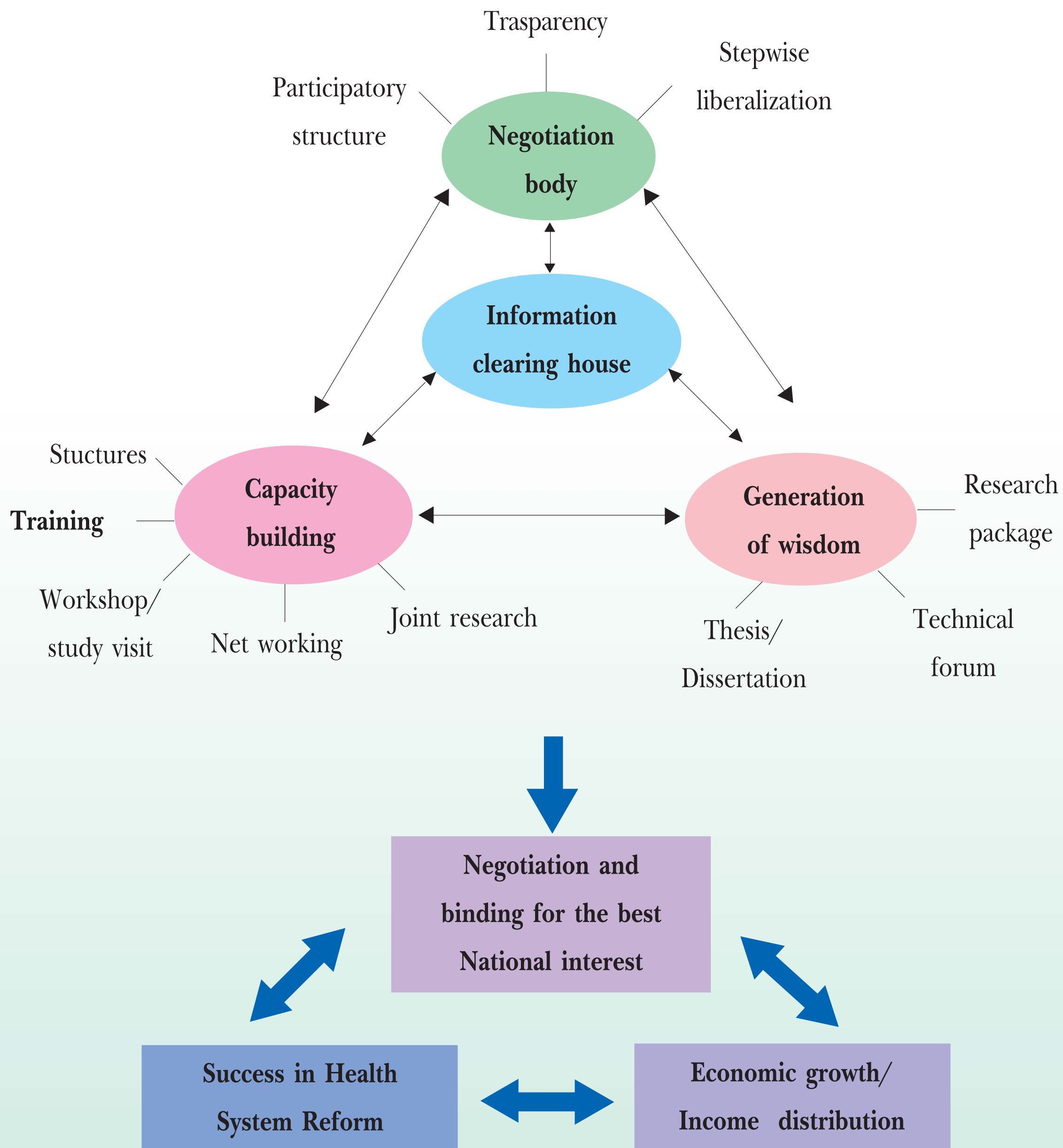


Figure 10.10 Trade negotiation structures - Thailand