Policy and practice

Trade policy and health: from conflicting interests to policy coherence

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Abstract Policy incoherence at the interface between trade policy and health can take many forms, such as international trade commitments that strengthen protection of pharmaceutical patents, or promotion of health tourism that exacerbates the shortage of physicians in rural areas. Focusing on the national policy-making process, we make recommendations regarding five conditions that are necessary, but not sufficient, to ensure that international trade policies are coherent with national health objectives. These conditions are: space for dialogue and joint fact-finding; leadership by ministries of health; institutional mechanisms for coordination; meaningful engagement with stakeholders; and a strong evidence base.

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Introduction

The links between trade agreements and health have been the subject of intense international debate in policy and academic circles in recent years, following the signing of the World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). TRIPS has created a new global regime of patent protection that, when applied to pharmaceutical drugs, can increase drug prices. Therefore, many observers and political actors worry that this trade agreement, together with new bilateral and regional trade agreements that further strengthen patent protection, will reduce access to pharmaceutical drugs in developing countries, especially among the poorest households. The debate about trade and health also reflects worries about the impact of international trade on health systems. For instance, increased liberalization and trade flows in agricultural products may increase risks associated with food safety and the international transmission of disease. The policy implications of making trade commitments in health services are also much debated.[1] Should national governments open up hospital services and health insurance to foreign investors and providers? Should health tourism, that is patients travelling abroad to receive medical care, be promoted as an export industry?

Policy incoherence marks different facets of the interface between trade policy and health. For instance, several bilateral and regional trade agreements encourage the adoption of legislation that does not allow sufficient flexibility in the protection of pharmaceutical patents.[2,3] These trade commitments can greatly restrict the capacity of government to ensure drug affordability. The liberalization of trade in health services also poses risks in terms of access. For example, the active promotion of health tourism can exacerbate the shortage of doctors in rural areas because of internal brain drain. We offer insights and recommendations on how policy-makers can work towards achieving more coherent policies at the intersection between trade and health.

Policy coherence and its political context

Policy coherence can be defined as "a process through which governments make efforts to design policies that take account of the interests of other policy communities, minimize conflicts, maximize synergies and avoid unintended incoherence. A degree of incoherence may sometimes be inevitable, but trade-offs should be transparent and appropriate measures taken to mitigate negative impacts."[4] Why do some national governments fail to adopt trade policies that are coherent with their health objectives? Trade and health policies are influenced by the nature of the political process and therefore, "technical analysis of the economic and health aspects is necessary, but not sufficient".[5] One important theoretical contribution to understanding why some policy options are adopted, and others blocked, comes from political economy, which stresses the distributional consequences of public policies and the dilemmas of collective action.[6–8] This well-established approach highlights how dispersion and concentration of the costs and benefits associated with policies will influence the incentives for collective action. When the benefits of a policy change are large and concentrated among a small group of actors, the group has a strong incentive for acting collectively to support the proposed policy change, and is much more likely to have an influence on the policy-making process. On the other hand, diffuse interests (where minor advantages are expected for a large number of individuals) generally have less influence over the policy process, given

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difficulties encountered in organizing large groups of individuals.

Social scientists have found this theoretical approach very useful to explain the formulation of trade policy,[9] and have recently expanded this approach to explain other aspects of economic foreign policy, such as policies regarding international finance and exchange rates, and foreign investments. In the case of trade policy as it relates to health, the theory would predict that the policy preferences of actors with a large benefit to reap would prevail. If these actors are large pharmaceutical companies or international firms involved in health insurance or investment in health facilities, their stakes in standards of protection for intellectual property or decisions about liberalization in health services or insurance are high and the number of actors relatively small; hence, there are strong incentives to be politically active and it is relatively easy to associate these actors in a single, effective organization. In comparison, groups uniting patients or consumers tend to be less organized. Given the influence of interests, achieving policy coherence is therefore not simply a question of adopting the procedural measures suggested below. We focus here on some steps that policy-makers in national governments can adopt to facilitate the adoption of trade policies that do not hinder the achievement of national health objectives.

Conditions to ensure policy coherence

Dialogue and joint fact-finding

Policy-makers and analysts from health and trade sectors form different epistemic communities, who may not share beliefs about cause and effect, or have the same values that inform how to develop a trade position or to implement trade commitments. Therefore, dialogue — informal and formal exchanges between trade and health officials at the national, regional and global level — is needed. In addition to fostering dialogue, one effective way to develop common understanding is to undertake joint fact-finding exercises. Each party can learn from having to work together on identifying a research agenda or a work programme that will explore the potential benefits and threats related to the policy under scrutiny. Such joint fact-finding does not result in all parties sharing the same views and interests, but it can clarify the trade-offs that are at stake and the possible policy responses to minimize negative impact.

The case of protection of intellectual property rights in regional trade agreements in Central America illustrates the importance of having health officials and trade officials engaged in dialogue and joint fact-finding exercises. Bilateral and regional trade agreements, such as the United States–Central America Free Trade Agreement (CAFTA), lead to patent protection on pharmaceutical drugs beyond that required by the multilateral regime created by TRIPS. Trade negotiations are usually based on the mutual exchange of market-access concessions; for instance, country A agrees to open its market to the sugar exports of country B in exchange for better access to the telecommunications market of country B. In this case, the United States of America (USA) requested strengthened patent protection in exchange for better access to its markets. More dialogue and joint fact-finding would give trade officials a better understanding of the implications of agreeing to strengthened patent protection. It would also mean that health officials would be better equipped to engage in discussions about the economic costs and benefits for their countries of receiving better access to American markets. Once officials have a better understanding of the risks and the potential benefits involved, together they may be able to design an alternative approach or complementary domestic measures. For instance, the results of a study conducted by the Costa Rican trade ministry suggested that the short-term impact of increased patent protection would be limited, especially when weighed against the potential benefits of access to American markets. However, this fact-finding exercise was not conducted in collaboration with actors from the health sector. Hence, the long-term impact of increased patent protection on access to drugs and the policy options available to counteract the impact of CAFTA on drug prices (such as parallel importation of drugs and the use of compulsory licenses) were not fully explored.

Leadership by health ministries

Several cases involving interaction between trade and health policy highlight the importance of leadership by the ministry of health in order to ensure policy coherence. The key position that the ministry of health can occupy is illustrated by the example of Malaysia; the proactive role of this ministry was clear in the decision to import generic antiretroviral drugs under the "government use" provision of TRIPS. Indeed, the ministry faced strong opposition, even within the national government cabinet, owing to concerns that such action would deter future foreign investment in Malaysia. Finally, thanks to strong political support, the cabinet was convinced and authorization was obtained to import these drugs for a period of two years, beginning on 1 November 2003.[10]

In contrast, Latin American countries like Argentina, the Dominican Republic, Guatemala, and Mexico provide us with examples of situations in which health ministries had little or no involvement in trade negotiations or the implementation of trade agreements. Given this lack of involvement, the national legislation implementing TRIPS in Latin America did not take full advantage of the flexibilities embedded in TRIPS to ensure accessibility to pharmaceutical drugs. The lack of leadership by the health authorities was probably the result of their limited knowledge about trade rules on access to medicines, as well as their usually low level of influence outside their specific field of competence. Historically, health ministries have been marginalized in two ways; first excluded from foreign policy, and, second, disconnected from other policy areas within domestic policy-making. Consequently, health-ministry officials have often been in more frequent contact with their counterparts abroad than with officials in trade or foreign ministries at home. Ensuring that ministries of health take a leadership role on trade and health policy therefore requires a reversal of long-held practices.

Institutional mechanisms of collaboration

To achieve coherence, institutional mechanisms often need to be created to ensure collaboration between organizations. In several countries, a national inter-ministerial committee plays this role, fostering coherence across the large number of issues that are affected by trade policy: procurement, environmental policies, public services and so on. In some countries, the public health authorities are members of this committee. Some countries prefer a special

mechanism devoted to trade and health coordination.[11] Indeed, institutional mechanisms can take many forms, and can be more or less formal in nature. While some include the private sector and representatives from civil society, others include only government officials. Institutional mechanisms aim to create incentives for collaboration, and, with time, to build trust between actors not used to working together.

For instance, in Thailand, the Ministry of Commerce was the only institution involved in the trade negotiations for Thailand until 1995–1996. However, the structure for international trade negotiation in Thailand was reformed in 1997 and many more stakeholders became involved, including all concerned ministries, private sectors, academicians and civil societies. The Ministry of Commerce is still the central agency, and is responsible for the secretariat of the National Committee on International Trade Policy, but the new infrastructure provides an umbrella for development of human capacity and for networking of all stakeholders. Thus, in 1998, the Ministry of Public Health established a Ministerial Committee on Health Impact from International Trade, with three subcommittees related to TRIPS, the Agreement on the Application of Sanitary and Phytosanitary (SPS) Measures and the Agreement on Technical Barriers to Trade (TBT), and the General Agreement on Trade in Services (GATS); each was assigned a secretariat. These subcommittees were all ad hoc structures, but have provided useful outcomes, including the realization among officials of the significance of international trade in health in Thailand and the networking of stakeholders. The regular meetings resulted in a better understanding among stakeholders, as well as clearer national positions for the national negotiation team.

The United States' Trade Policy Staff Committee for SPS Affairs is another example of an institutional mechanism that allows cross-sectoral collaboration and trust-building over time. This committee is the American inter-agency structure responsible for formulating trade policy as it relates to food standards, and for resolving agency questions or policy divergence. The United States Trade Representative coordinates the group of eight agencies, but the mechanism guarantees an appropriate voice for all relevant government players in the health and trade sectors. The USA food safety agencies provide technical and policy expertise and guidance, but do not serve in a trade promotion role. Rather, they see their role as ensuring that health protection is not compromised by trade priorities.

Engage stakeholders

Bringing a wide range of governmental and nongovernmental actors into the policy process is critical to ensuring policy coherence. This is an effective way to ensure that divergent views and interests are included in an explicit and transparent manner in the balancing act of policy-making (especially if stakeholders are engaged and consulted early in the policy process). The case of patent legislation in Sri Lanka highlights the importance of engaging with civil society to achieve coherence. In the context of bilateral trade negotiations with the USA in 2003, new patent legislation was adopted without broad consultation. However, the new law did not allow compulsory licensing and parallel importing, which are understood to be important tools to ensure affordable access to pharmaceutical drugs.[12] Several Sri Lankan activists and legal advocates challenged the bill in the Supreme Court; the court agreed that the constitution prevented the government from introducing legislative measures that would knowingly increase inequality, or deny people equal access to equal health services. When it came time to revise the bill, government officials consulted a variety of stakeholders and civil society organizations, which unanimously supported a new draft of the legislation to include flexibilities for compulsory licensing and parallel imports.[13]

There are several examples of the positive contribution made by public consultation in the formulation of trade policy relevant to health. In the case of the offers made by Pakistan in the GATS negotiations as they related to health services, the Ministry of Health was consulted and in turn engaged in discussions with various associations representing health professionals. In reaction to comments received during these discussions, Pakistan made an offer on professional services in the health sector that included a public-services "carve-out", i.e. that excludes health services provided by public institutions. The objective of this exclusion was to ensure future regulatory flexibility to improve accessibility to health services, either through subsidies, universal services obligations or other measures.

Get the evidence right

Trade and health officials need detailed information to be able to make informed choices about how to balance divergent interests and views. In Thailand, the Ministry of Health developed estimates of the economic costs of the "TRIPS-plus" provision proposed in the Thailand–United States Free Trade Agreement,[14] the USA having asked for a longer data-exclusivity period that would effectively prolong patent protection. In the case of the bilateral negotiations with the USA, the main recommendation of the ministry was to prefer intellectual property provisions with no negative public-health implications, i.e. no TRIPS-plus provision, but the ministry also offered an alternative position that attempted to minimize the negative impacts of TRIPS-plus provisions.

The capacity to monitor the impact of trade policy after adoption is also crucial to be able to prepare an appropriate response. For example, Thailand has seen a large increase in the number of foreign patients coming to receive medical care. The Ministry of Health has been monitoring the impact of health tourism and found that the increased demand for doctors and nurses to care for foreign patients has led to an internal brain drain from the rural public sector to the urban private sector. Thanks to this monitoring capacity, the ministry could adopt a policy for scaling-up the training of doctors and nurses under a special curriculum to facilitate rural distribution.[15]

In some cases, in order to pool limited resources, a regional approach to collecting the information that is required to ensure that trade policy reflects health needs can be preferred to a national approach.[16] The Secretariat of the Common Market on Eastern and Southern Africa, in partnership with officials in each member country, is coordinating comprehensive assessments of the state of trade in services (including health services) in this region, in preparation for economic partnership agreements with the European Union and GATS negotiations. This regional approach is also relevant for other elements of the policy process discussed here, such as the need to create institutional mechanism for collaboration. Many low-income

countries may not have the resources to create a distinct unit or committee to deal with trade and health, and regional collaboration may be the best way to ensure internal coherence.

International organizations such as the World Health Organization and the World Trade Organization also have an important role to play in developing the evidence relevant to trade and health policy and making it accessible to policy-makers. Their technical assistance and capacity-building activities need to be coordinated and strengthened to ensure that trade and health officials receive appropriate information so they can engage in national policy discussions.

Conclusions

We have discussed five conditions that are necessary to ensure coherence between health and trade policy. Together, these conditions make it more likely that trade reforms will, at the very least, not worsen health outcomes or the social conditions that lead to ill health. However, even a strong ministry of health whose officials are armed with good information, that is actively involved in an inter-ministerial committee on trade, and that is building common ground and supported by a broad coalition of stakeholders, cannot guarantee a particular outcome. For instance, during bilateral trade negotiations with the USA, the government of Peru agreed to several TRIPS-plus provisions, despite opposition from a wide variety of civil society groups (such as public health actors and human rights groups), and despite a visit and press release from the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.[17] The government also had well-documented studies on the impact of strong patent protection on access to drugs. This is a reminder that trade policy-making is embedded in a larger complex political process, and that our recommendations can be seen as necessary, but not sufficient, conditions for policy coherence. ■

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Résumé

Politique commerciale et santé : passer des conflits d'intérêts à une action cohérente

L'incohérence des politiques à l'interface entre la politique commerciale et la santé peut prendre de nombreuses formes, par exemple les engagements commerciaux internationaux qui renforcent la protection des brevets pharmaceutiques ou la promotion du tourisme de santé qui agrave la pénurie de médecins en milieu rural. En mettant l'accent sur l'élaboration des politiques au niveau national, l'article formule des recommandations concernant cinq conditions nécessaires, mais non suffisantes, pour que les politiques commerciales internationales soient compatibles avec les objectifs sanitaires nationaux, à savoir : ménager une place au dialogue et à une action commune d'établissement des faits ; conférer un rôle de premier plan aux ministères de la santé ; prévoir des dispositifs institutionnels de coordination ; solliciter à bon escient l'implications des parties prenantes ; et disposer de bases factuelles solides.

Resumen

Políticas comerciales y salud: de los intereses enfrentados a la coherencia normativa

La incoherencia normativa en el terreno de interacción de las políticas comerciales y la salud puede reflejarse en muchos aspectos, como los compromisos comerciales internacionales que refuerzan la protección de las patentes farmacéuticas, o el fomento de un turismo sanitario que agrava la escasez de médicos en las zonas rurales. Centrándonos en el proceso de formulación de políticas nacionales, hacemos algunas recomendaciones respecto a cinco condiciones que son necesarias, pero no suficientes, para asegurar que las políticas comerciales internacionales sean coherentes con los objetivos de salud nacionales. Esas condiciones son un espacio para el diálogo y la investigación conjunta, el liderazgo de los ministerios de salud, los mecanismos institucionales de coordinación, una participación significativa con los interesados directos y una base evidencial sólida.

ملخص

سياسات التجارة والصحة: من المنافع المتضاربة إلى الاتساق في السياسات

يأخذ عدم الاتساق في السياسات في النواحي المشتركة بين سياسات التجارة والصحة أشكالاً عدة مثل الالتزامات التجارية العالمية التي تعزز من حماية حقوق الملكية للمستحضرات الصيدلانية، أو تعزيز السياحة الصحية التي تفاقم من نقص الأطباء في المناطق الريفية. وقد ركزنا على عملية اتخاذ القرار السياسي الوطني فوضعنا توصيات تتعلّق بخمس حالات تتسم بأنها ضرورية ولكنها ليست كافية لضمان اتّساق السياسات التجارية العالمية مع المرامي الصحية الوطنية: وهذه الحالات هي: إفساح مساحة للحوار وتقصّي الحقائق، القيادة لوزراء الصحة، الآليات المؤسسية للتنسيق، الانخراط الحقيقي مع المؤثّرين في الحالات، وأساس متين من البيِّنات.

References

1. Blouin C, Drager N, Smith R, editors. *International trade in health services and the GATS: current issues and debates*. Washington DC: World Bank; 2006.
2. Correa C. Implications of bilateral trade agreements on access to medicines. *Bull World Health Organ* 2006;84:399-404.
3. Drahos P. *Developing countries and international intellectual property standard-setting*. London: Commission on Intellectual Property Rights; 2001. Study Paper No. 8. Available from: http://www.iprcommission.org/papers/pdfs/study_papers/sp8_drahos_study.pdf
4. Organisation for Economic Co-operation and Development. *Policy coherence for development: promoting institutional good practice*. Paris: OECD; 2005:17.
5. Reich MR. The politics of health sector reform in developing countries: Three cases of pharmaceutical policy. *Health Policy* 1995;32:47-77.
6. Olson M. *The logic of collective action: public goods and the theory of groups*, Cambridge, MA: Harvard University Press; 1971.
7. Colander D, editor. *Neoclassical political economy: the analysis of rent seeking and DUP activities*. Cambridge, MA: Ballinger Publishing Co.; 1984.
8. Srinivasan TN. Neoclassical political economy. the state and economic development. *Asian Dev Rev* 1985;3:38-58.
9. Frieden J, Lake D, International relations as a social science: rigor and relevance, *The Annals of the American Academy of Political and Social Science* 2005;600:136-56.
10. Musungu S, Oh C. *The use of flexibilities in TRIPS by developing countries: Can they promote access to medicine?* Geneva: Commission on Intellectual Property, Innovation and Public Health; 2005. Study 4C. Available from: http://www.who.int/intellectualproperty/studies/TRIPS_flexibilities/en/index.html
11. Latif AA. *Developing country coordination in intellectual property standard-setting*. Geneva, South Centre; 2005. South Centre TRADE Working Papers No 24.
12. Keayla BK, editor. *Review of patent legislation of India, Indonesia, Sri Lanka and Thailand: measures to safeguard public health*. New Delhi: WHO Regional Office for South-East Asia; 2004. Available from: http://whqlibdoc.who.int/searo/2004/SEA_HSD_275.pdf
13. Balasubramaniam K. Special Determination of the Supreme Court (No 14/2003, 15/2003, No 16/2003) The TRIPS Agreement, the Doha Declaration and the Intellectual Property Bill 2003. *Law and Society Trust Review* 2003;13(189). Available from: http://www.lawandsocietytrust.org/LSTReview.asp?VolNo=30&List=True
14. Third World Network, Developing countries warned against WTO-plus issues and rules in FTAs, *South North Development Monitor*, 31 August 2005.
15. Pachanee CA, Wibulpolprasert S. Incoherent policies on universal coverage of health insurance and promotion of international trade in health services in Thailand. *Health Policy Plan* 2006;21:310-8.
16. Reichman JH. *Managing the challenge of globalized intellectual property regime*. Geneva, International Centre for Trade and Development; 2003. ICTSD/UNCTAD Dialogue, Bellagio Series on Development and Intellectual Property. Available from: http://www.iprsonline.org/unctadictsd/bellagio/docs/Reichmann_Bellagio2.pdf
17. Hunt P. *The right of everyone to the enjoyment of the highest attainable standards of physical and mental health*. Geneva: Commission on Human Rights; 2006. Annual report No. E/CN.4/2006/48.