The EU's Bilateral FTA Negotiations are a Threat to the Right to Health

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Platform for Action on Health and Solidarity – Working Group on North-South Solidarity Issues

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"*Unfortunately, to date, the health sector has been a strikingly absent advocate in fighting for a fairer trade system. If health professionals have engaged in trade issues, it is most likely in the Trade Related Aspects of Intellectual Property Rights (TRIPS) which has hindered access to live-saving medicines for many people in low-income settings. (…) But as important as TRIPS is, health professionals should have a broader knowledge of trade issues so that the health sector can become a more effective advocate in reshaping the political debate about trade's impact on health*."[1]

[1] MacDonald R, Horton R. Trade and health: time for the health sector to get involved. Lancet, Volume 373, Issue 9660, Pages 273 - 274, 24 January 2009

1. Contents

2. List of abbreviations

ACP Countries: African, Caribbean and Pacific countries

ACTA: Anti-Counterfeiting Trade Agreement

ASEAN: Association of Southeast Asian Nations

CAFTA: Central America Free Trade Agreement

CAN: Countries of the Andean Community

CPC: Central Product Classification

EAC: Eastern African Community

EC: European Commission

EPA: Economic Partnership Agreement

ESA: Eastern and Southern Africa

EU: European Union

FTA: Free Trade Agreement

GATT: General Agreement on Tariffs and Trade

GATS: General Agreement on Trade in Services

IP: Intellectual Property

IPR: Intellectual Property Rights

MDG: Millennium Development Goal

Mercosur: Mercado Comun del Sur

NGO: Non Governmental Organization

SADC: Southern African Development Community

SIDS: Small Islands Developing States

TRIPS: Trade-Related Intellectual Property Rights

UN: United Nations

UNCTAD: United Nations Conference on Trade and Development

US: United States of America

WIPO: World Intellectual Property Organization

WTO: World Trade Organization

3. Introduction

Our world is a globalized world. An almost blind belief in the powers of the market, often referred to as 'neo-liberalism', has been the dominant ideology since the end of the Cold War. Under this belief, the liberalization of trade, to be understood as the lowering of restrictions on the cross-border movement of goods, services and investment capital would bring prosperity and development. Interestingly, even in the midst of the recent economic and financial crisis, this belief remains widely untouched.

Since the early 1990s, the United States has been aggressively pushing bilateral free trade and investment agreements on developing countries. The European Union has followed this trend, especially since a great number of developing countries have made a stand against further trade liberalization under the multilateral system of the World Trade Organization (WTO).

As a result, the EU is currently pursuing free trade agreements with individual countries and groups of countries including:

- African, Caribbean and Pacific (ACP) Countries, the so-called Economic Partnership Agreements (EPAs);
- Association of Southeast Asian Nations (ASEAN);
- Countries of the Andean community (CAN): Colombia and Peru;
- Central American countries (CAFTA);
- Mercosur;
- India.

These bilateral agreements do not replace but complement commitments under the WTO and cover a wide range of issues including investments, trade in services, intellectual property rights, competition policy and government procurement. Their provisions go beyond those of the WTO commitments. Moreover, it is often these provisions that were blocked by poor countries at the WTO negotiations that are now being repackaged in the bilateral free trade negotiations.

As Karel De Gucht, the EC commissioner for trade, pointed out during his hearing at the European Parliament in January 2010, the European Commission believes that: "*We must complement the multilateral system by strengthening key bilateral and regional relationships. This is because* ***bilateral agreements can go further and faster*** *in promoting openness and integration, by tackling issues which are not ready for multilateral discussion and by* ***preparing the ground for the next round of multilateral negotiations****. Many key issues, including investment, public procurement, competition, intellectual property, and other regulatory questions, which are currently insufficiently covered by*

the WTO, can be addressed in such agreements."[2]

The European Commission is well aware that its trade policies have potential impacts on other areas, including health. That is why the principle of policy coherence is supported by successive treaties of the European Union as well as by the European Consensus on Development. As development cooperation alone cannot meet the needs of developing countries, the EU identified in 2005 Policy Coherence for Development (PCD) as a key concept in achieving poverty eradication and advancing the Millennium Development Goals (MDGs). A recent report by CONCORD, the European NGO confederation for relief and development, concluded that the EU's PCD mechanisms have serious deficiencies and loopholes and that EU policies, including its trade policies, continue to undermine the economic social and human development of developing countries.[3]

There are reasons to believe that bilateral FTAs will threaten the ability of developing countries to deliver health for all. Health is at the heart of the international poverty reduction agenda through the Millennium Development Goals (MDGs) and other commitments. Under Goal 4, the world is committed to reducing child mortality; under Goal 5 to improving maternal health and under Goal 6 to combating HIV/Aids, Malaria and other diseases. With only five years left for reaching the MDGs in 2015, the world should make sure that its policies at least do not hamper the MDGs.

Health is not only central to the Millennium Development Goals, but it is a basic human right, entrenched in several international conventions and declarations, such as the Universal Declaration of Human Rights and the Covenant on Economic, Social and Cultural Rights. Moreover, several countries included the right to health in their national constitution. The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to clean water and sanitation, adequate housing and nutrition as well as social determinants such as gender, racial and ethnic discrimination and disparities, all of which are significantly influenced by trade agreements.[4]

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[2] De Gucht, K.: Answers to European Parliament, Questionnaire for Commissioner-designate Karel De Gucht (Trade), 12 January 2010. Available on http://www.europarl.europa.eu/hearings/static/commissioners/answers/de_gucht_replies_en.pdf, last accessed 10 April 2010.

[3] CONCORD. Spotlight on Policy Coherence Report 2009. Available on http://www.concordeurope.org/Files/media/internetdocumentsENG/5_Press/1_Press_releases/00pressreleases2009/CONCORD_PCD-Spotlight-report_light.pdf, last accessed on 27 January 2010.

[4] Committee on Economic, Social and Cultural Rights (2000): Substantive Issues arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment N.14: the right to the highest attainable standard of health. Available on http://www2.ohchr.org/english/, last accessed on 06 January 2010.

Healthcare deserves special attention in trade policies not only because it is a basic human right and has an important role in development, but also because it is prone to market failure. The TRIPS agreement of the WTO, for example, has been criticized from its very inception for its negative impact on access to medicines. However, it is only recently that the relation between trade liberalization and the right to health has been examined more systematically. In 2004 Paul Hunt, the first UN Special Rapporteur on the right to health, wrote in his report on a mission to the WTO[5] that "*trade impacts on the right to health in numerous ways*", and "*States have to ensure that the trade rules and policies they select are consistent with their legal obligations in relation to the right to health."*

Hunt explains that:

"International human right law takes a position neither for nor against any particular trade rule or policy, subject to two conditions: first, ***the rule or policy in question must, in practice, actually enhance enjoyment of human rights****, including for the disadvantaged and marginal; second,* ***the process by which the rule or policy is formulated, implemented and monitored must be consistent with all human rights and democratic principles.*** *Thus, if reliable evidence confirms that a particular trade policy enhances enjoyment of the right to health, including for those living in poverty and other disadvantaged groups, and that policy is delivered in a way that is consistent with all human rights and democratic principles, then it is in conformity with international human rights law. However,* ***if reliable evidence confirms that a particular trade policy has a negative impact on the enjoyment of the right to health of those living in poverty or other disadvantaged groups, then the State has an obligation under international human rights law to revise the relevant policy.****"*

It is thus imperative that, at a minimum, trade and economic policies should do no harm to health. Therefore, while negotiating trade agreements, special attention must be paid to their potential impact on health, particularly on population health, on the risks to health, on the resources available for health and on universal access to health services. All trade agreements should be subject to an assessment of health impacts, publicly debated before signing.

The Platform for Action on Health and Solidarity, a platform composed of trade unions, mutual health insurance funds and development NGOs, wants to open the debate. In December 2009 a first round table took place at which various trade and health specialists participated. The

[5] Report on Mission to the World Trade Organization (E/CN.4/2004/49/Add.1) submitted to the Commission on Human Rights on 1 March 2004.

discussions that took place there together with our own research form the basis of this dossier, which constitutes the background document for our campaign and lobby work from 2010 onwards.

In what follows, there will be first a brief outline of the European FTA policy. Then, four major issues will be discussed that show how the current FTAs are putting the right to health at risk:

- FTAs have a potential negative impact on the social determinants of health;
- How FTAs will cause a loss of government revenue, making it more difficult to make investments in vital sectors such as health and education;
- The EU aims to include the liberalization of services in FTAs. Also the health sector, as one of the faster growing sectors in the global economy, might be opened for European competition. This would make the commercialization of health services irreversible.
- The EU aims to include so-called TRIPS-plus rules in the FTAs, making it more difficult for states to make use of the WTO flexibilities to protect public health. Access to medicines will be compromised.

4. Rules governing Free Trade Agreements

4.1 From GATT to WTO

For almost half of the last century, the General Agreement on Tariffs and Trade (GATT) was the most important international framework shaping the global trade regime. GATT was formed in 1947 with the objective of reducing the barriers to international trade. Therefore, multilateral agreements were negotiated in different "rounds" to reduce tariff barriers, quantitative restrictions and export subsidies.

Since the end of the Cold War, the ascent of neo-liberal globalization has accelerated the expansion of international trade. Trade liberalization was promoted by international institutions as an important economic strategy towards development and poverty reduction. Consequently, the Uruguay Round of the GATT negotiations (1986-1993) gave birth to the World Trade Organization (WTO) which came into being on January 1, 1995.

Unlike GATT, which only had a small secretariat, the WTO is a strong organization that covers a scope that is much more encompassing. When established in 1947, GATT had 23 contracting parties and was limited to trade in goods. Today, the WTO has 153 members (which account for 97% of world trade), with another 29 countries seeking accession, and includes trade in goods and services and the protection of intellectual property rights.[6]

The following four features of the international trade policy system explain why it has so far overshadowed the international health governance system.

1. The strategic objective of trade liberalization within a multilateral system has produced a core structure with strong legal foundations and the incentive and capacity to handle new issues.
2. The WTO's membership is extensive and expanding and the scope of issues covered by WTO agreements is vast.
3. WTO agreements place extensive demands on individual countries. For example, to become a WTO member, a country has to agree to no less than 17 main multilateral agreements and 60 agreements, annexes, decisions and understandings that contain binding obligations on a myriad of issues.
4. The WTO is able to reinforce compliance with its rules through its dispute settlement mechanism.

[6] Fidler D, Drager N, Lee K. Managing the pursuit of health and wealth: the key challenges. Lancet, Volume 373, Issue 9660, Pages 325 - 331, 24 January 2009

By contrast, global health governance exhibits little structural coherence, a greater diversity of actors and approaches, and weaker legal obligations on states.[7]

4.2 GATT Article XXIV and GATS Article V

As has been explained in the introduction, FTAs are now an important feature of international trade relations. Already in 2003 after the refusal to negotiate Singapore issues[8] at the Doha Round of WTO negotiations, the US moved forward bilaterally with countries ready to negotiate.

Although the EU insisted initially on the importance of multilateral negotiations at the WTO, it started bilateral negotiations in all directions since 2007 in order not to fall behind. So, especially since the deadlock of the Doha Round, a real spaghetti bowl of FTAs is being created, with the EU and US trying to insert issues which in the multilateral framework had been blocked by the developing countries.

Bilateral FTAs can be made between two countries but also between an individual country and a group of countries, and even between two groups of countries (e.g. the EU and ASEAN). Just like the WTO agreements, they usually cover a wide range of issues including investments, trade in services, intellectual property, etc.

FTAs are actually a departure from the non-discriminatory principles of the WTO.[9] As long as the outcome is in conformity with the rules of the WTO, the parties can determine the content of these agreements. The rules for FTAs can be found in Article XXIV of the General Agreement on Tariffs and Trade for trade in goods and in Article V of the General Agreement on Trade in Services (GATS) for trade in services. Developing countries can also negotiate preferential trade arrangements among themselves under more flexible provisions of the Enabling Clause.[10]

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[7] Ibid.

[8] The term "Singapore issues" refers to four working groups set up during the 1996 WTO in Singapore. These groups were tasked with rules covering government procurement, trade facilitation (customs issues), trade and investment, and trade and competition. These issues were pushed at successive ministerials by the European Union, Japan and Korea, and opposed by most developing countries.

[9] The two important principles of the WTO that have to ensure trade without discrimination are the so-called most-favored nation principle and the principle of national treatment. The former prescribes that if a country grants a certain favor to one trading partner, it should also grant it to all others. The latter says that imported and locally-produced goods should be treated equally.

[10] In 1979, as part of the Tokyo Round of the GATT, the enabling clause was adopted in order to permit trading preferences targeted at developing countries which would otherwise violate its article I.

Article XXIV of the GATT defines a free-trade area as *"a group of two or more customs territories in which the duties and other restrictive regulations of commerce . . . are eliminated on substantially all the trade between the constituent territories in products originating in such territories."* [11] The Understanding of the Interpretation of Article XXIV of the General Agreement on Tariffs and Trade of 1994 which is part of the Uruguay Round outcomes, states that the contribution of free-trade agreements to the expansion of world trade through closer economic integration would be "*diminished if any major sector of trade were excluded*".[12]

The WTO rules for creating free-trade agreements for services are listed in Article V of the GATS where they are called Economic Integration Agreements. According to this Article, WTO members may enter into an agreement to liberalize trade in services through a free-trade agreement if the agreement (1) has substantial sectoral coverage, expressed in terms of numbers of sectors, volume of trade affected and modes of supply, (2) eliminates substantially discrimination in national treatment in the sectors covered and/or (3) prohibits new or more discriminatory measures in these sectors and (4) does not raise barriers against non-members.[13]

4.3 Bilateral or multilateral: does it matter?

Multilateral trade agreements under the WTO have been criticized for being lopsided to benefit the industrialized countries. Generally speaking, the same applies to bilateral FTAs between rich and poor countries. However, FTA negotiations between a developing country and a developed country pose additional reasons for concern:[14]

- First of all, FTAs are usually negotiated with little transparency or participation from the public. Civil society involvement during the negotiations is generally very limited or even non-existant;

- Developing countries are usually in a weaker bargaining position due to the lack of capacity of their economies, their weaker political situation and their weaker negotiating resources;

- In the WTO, the principle of special and differential treatment (for

[11] The General Agreement on Tariffs and Trade (1947), Article XXIV. Available on http://www.wto.org/english/docs_e/legal_e/gatt47_02_e.htm, last accessed on 06 January 2010.

[12] The Understanding of the Interpreation of Article XXIV of the General Agreement on Tariffs and Trade 1994, available on http://www.wto.org/english/docs_e/legal_e/10-24_e.htm, last accessed on 06 January 2010.

[13] The General Agreement on Trade in Services, Article V. Available on http://www.wto.org/english/docs_e/legal_e/26-gats_01_e.htm,last accessed on 10 April 2010.

[14] Third World Network: EU EPAs: Economic and Social Development Implications: the case of the CARIFORUM-EC Economic Partnership Agreement, February 2009. Available on http://www.twnside.org.sg/pos.htm, last accessed on 06 January 2010.

developing countries) is recognized. Developing countries are, on paper at least, not obliged to open up their markets (or undertake other obligations) to the same degree as developed countries. Most FTAs, on the other hand, are basically on the basis of reciprocity;

- The FTAs contain many items that are not part of the rules of the WTO. Developing countries successfully succeeded in thwarting the inclusion of rules on investment, government procurement and competition law as subjects for WTO negotiations or rules. However, all these topics are now entering by the side-door through the FTAs;

- Even where issues are already the subject of rules in the WTO (intellectual property and services), there were flexibilities and options open to developing countries in interpreting and in implementing obligations in these areas. However, there are attempts by developed countries to remove these flexibilities for developing countries in the FTAs.

5. The EU and the FTAs

To understand the EU approach in its FTAs, we should first have a closer look at its guiding principles, which can be found in two basic documents: The Lisbon Strategy and Global Europe.

5.1 The Lisbon strategy

In March 2000, during the Summit of Lisbon, European leaders adopted the Lisbon strategy. This strategy aims at making the EU "*the most dynamic and competitive knowledge-based economy in the world capable of sustainable economic growth with more and better jobs and greater social cohesion, and respect for the environment.*"[15] The objective was for Europe to become more competitive in the world market, especially in comparison to the US, through a number of key reforms. Better protection of Europe's trade interests, including the protection of intellectual property rights, is essential in this strategy.

The current discussions on the "EU 2020 Strategy", which will replace the Lisbon strategy and which is currently open for consultation, already shows that intellectual property protection remains key in European future policy.[16]

5.2 Global Europe and the new generation of FTAs

In '*Global Europe: Competing in the World*'[17], published in October 2006, the European Commission's Directorate General (DG) for Trade sets out the contribution of trade policy to stimulating growth and creating jobs in Europe. Global Europe identifies three main areas as priorities: (1) market opening and stronger rules in new trade areas, (2) improving access to resources such as energy, metals and primary raw materials including certain agricultural materials and (3) removing non-tariff barriers, such as norms and standards.

The focus of Global Europe is on raising the competitiveness of European companies. It clearly states that it aims in FTA-negotiations to tackle "*issues that are not ready for multilateral discussions*" and to ensure better access for EU companies to major public procurement markets.

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[15] European Commission: Lisbon Strategy for Growth and Jobs: towards a green and innovative economy. Available on http://ec.europa.eu/growthandjobs/index_en.htm, last accessed on 06 January 2010.

[16] European Commission: Consultation Paper on the Future EU 2020 Strategy. Available on http://ec.europa.eu/eu2020/index_en.htm, last accessed on 06 January 2010.

[17] European Commission, "Global Europe: Competing in the world", Speaking points by Commissioner Mandelson 4 October 2006. Available at http://trade.ec.europa.eu/doclib/docs/2006/october/tradoc_130369.pdf, last accessed on 10 April 2010.

Still stating that the conclusion of the Doha Development Round and a strong multilateral liberalization agreement remain an absolute priority for the EU, Global Europe sets out the framework for a new generation of FTAs. These FTAs are comprehensive in nature in that they extend market opening ambition to the international commerce in services, investment and government procurement.[18]

The EU tries to challenge all domestic policies and regulations that hinder the access to EU businesses, under the pretext that they are 'trade distorting'. For this, the EU makes use of two major strategies: (1) bilateral trade agreements and (2) market access teams. These teams, which are established in the European delegations abroad, analyse all possible barriers to the entrance of EU business in a country. When barriers are identified, they put pressure on the government to get the regulation changed.

In bilateral trade agreements, the EU argues that domestic regulation must be 'not more burdensome than necessary' or 'least trade distorting'. This puts trade above any other concern and even above public and social interests which implies that domestic regulations can be examined for their potential trade distorting aspects. "Whatever you do, it should not harm trade," is the rule.[19]

5.3 EU FTAs

The EU is currently involved in several negotiations for FTAs with developing countries: the Economic Partnership Agreements (EPA) with countries from Africa, the Caribbean and the Pacific, negotiations with ASEAN, the Andean Community of Nations (Peru and Colombia), Central America (CAFTA), Mercosur and India. Annex 1 contains a full overview of the FTAs being negotiated and the main issues related to health. Of these, the only full FTA so far is the EPA with the Cariforum countries. The Cariforum EPA not only contains the liberalization of goods, but also services, government procurement, competition policy and intellectual property rights. The WTO plus provisions in the Cariforum EPA will likely fuel attempts to see them replicated in other preferential agreements. Annex 2 shows in which way the Cariforum EPA will impact on public health in the Caribbean countries.

[18] South Centre: Negotiating Services Free Trade Agreements with the European Union: Some Issues for Developing Countries to Consider, June 2009. Available at http://www.southcentre.org/ARCHIVES/index.php?option=com_content&task=view&id=1021, last accessed on 10 April 2010.

[19] Maes, M.: "Introduction to FTAs and possible impact on health", presentation at the Round Table: The impact of the EU Free Trade Agreements on Pulbic Health", Brussels, 16 December 2009. Report available at www.gezondheid-solidariteit.be

6. Impact of FTAs on Health

The need for public health to be taken into consideration in negotiating FTAs has been highlighted not only in developing but also in developed countries. The European Parliament, for example, has highlighted its concerns on trade agreements and access to medicines and public health, more general in developing countries, through resolutions, recommendations and letters.[20] The European Commission likewise recognizes on its website that "*trade policy is closely linked to im*portant questions of public health".[21]

Not only are health services in developing countries becoming a more and more attractive investment opportunity, but pharmaceutical companies are also making good money by selling their medicines. For them, intellectual property enforcement is good for business.

The Commission on the Social Determinants of Health of the World Health Organization urged in its final report that *"caution be applied by participating countries in the consideration of new global, regional and bilateral economic – trade and investment – policy commitments. Before such commitments are made, understanding the impact of the existing framework of agreements on health, the social determinants of health and health equity is vital. Further, assessment of health impacts over time suggests strongly that flexibility, allowing signatory countries to modify their commitment to international agreements if there is adverse impact on health or health equity, should be established at the outset, with transparent criteria for triggering modification."* [22]

Consequently, as FTAs can directly affect access to healthcare as well as the broader determinants of health, there is a need for countries to assess multilateral and bilateral agreements for potential health impacts.

In particular, when we speak about FTAs and the right to health, we have

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[20] On 12 July 2007, there was as European Parliament resolution on the TRIPS Agreement and access to medicines (P6_TA(2007)0353), urging the EC not to demand for TRIPS plus provisions.
The following recommendations were given to the EC by the EP in 2008 in the context of the negotiaions with the Andean community: I) Using negotiating guidelines on development cooperation designed to achieve MDGs, including the protection of public health, ii) ensuring coherence of development policies in line with the principle enshrined in Article 178 of the EC Treaty, iii) granting high priority for greater access to health and education, iv) fostering regional integration by negotiating block by block, see X. Seuba (2009): 'Protectin Health in the EU Andean trade agreement', HAI paper series.

[21] European Commission, Trade: Wider Agenda, Health. Available on http://ec.europa.eu/trade/wider-agenda/health/, last accessed on 7 January 2010.

[22] Commission on Social Determinants of Health: "Final Report, Executive Summary: Closing the gap in a generation: health equity through action on the social determinants of health". World Health Organization 2008.

to look into four broad areas:

- Trade and the social determinants of health;
- Impact on government revenue;
- Liberalization of the health sector;
- Stronger intellectual property rights.

6.1 Trade and the social determinants of health

That trade has an effect on the social determinants of health, or the conditions in which people live and work that affect their opportunities to lead healthy lives, is clear but the exact pathways between them are not well known. However, four key factors have been identified in the literature: (1) income, (2) inequality, (3) economic insecurity, and (4) unhealthy diets.[23]

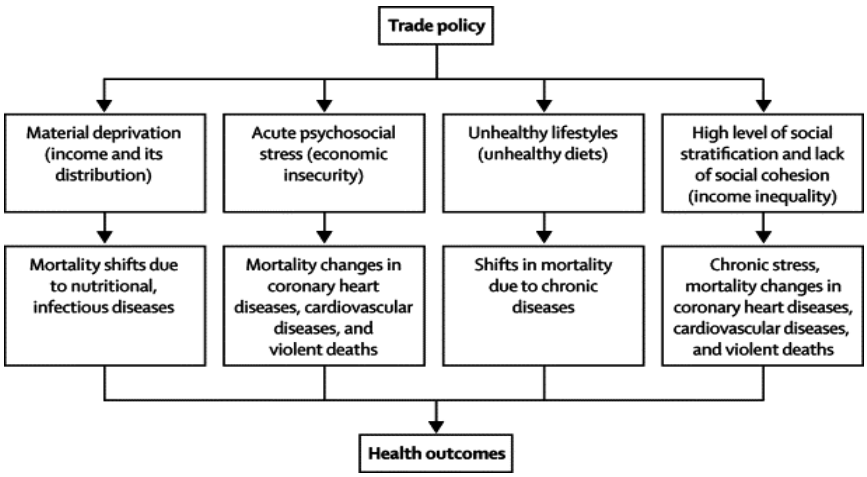

Table 1: Effect of trade policy on social determinants of health[24]

6.1.1 Income and its distribution

The general pro-liberalization argument is that liberalization leads to growth, which creates wealth, which decreases poverty, which improves health and which again increases growth. However, this relation is far from automatic. Moreover, trade reforms always create winners and losers: some sectors of the economy might not be able to compete with new imported goods whereas others get access to new markets and opportunities.

Also, individual incomes can alter because jobs can be created or lost and prices of and external demand for goods can rise or fall. Some losers from trade liberalization might be poor households whose incomes will fall fur-

[23] Labonté R., Schreker T.: "Globalisation and social determinants of health: introduction, methodological background (part 1 of 3). Global health 2007;3;5. http://www.globalizationandhealth.com/content/3/1/5, last accessed on 10 April 2010.

[24] C. Blouin, M. Chopra, R. Van der Hoeven: "Trade and Social Determinants of Health.", in The Lancet, Volume 373, Issue 9662, Pages 502-507, 7 February 2009.

ther. Ravaillon[25] argues that it is hard to maintain the view that expanding external trade is in general a powerful force for poverty reduction. It is further important to disaggregate the analysis, to check the outcomes of trade reform for different regions of the country, for urban versus rural households and for other relevant groups.

6.1.2 Inequality

Research done in many countries shows that tariff reduction and trade openness are associated with increased wage disparities, with a substantial rise in relative rewards for skilled labour whereas unskilled workers remain mainly engaged in informal activities.[26]

6.1.3 Economic insecurity

During trade reforms, job creation is generally accompanied by employment losses because labour moves from one sector or industry to another. This process needs social safety nets and smooth employment transition mechanisms to lessen material and psychological stress to workers and their families.[27]

6.1.4 Diet and Nutrition

Trade liberalization is one variable that can lead to alterations in diet and nutrition. Reduction in prices of unhealthy foods compared with healthy foods, increased desirability and availability of unhealthy foods, worsening asymmetry between consumers and suppliers of foodstuffs and growing urbanization and changes in lifestyle are all possible means by which trade liberalization could affect popular diets, especially those of poor populations.

We should note that poor households are most sensitive to food price changes and thus are likely to change their diet accordingly. Other elements to consider are the penetration of supermarkets or multinational fast-food outlets, availability of processed food, investments in marketing and advertising. However, more research is needed to show the relation.[28]

A recent study in Globalization and Health documented how average tariffs in Central America declined from 45% in 1985 to around 6% in 2000. Consequently, total food imports, especially processed foods, into the Central American countries more than doubled. The researchers concluded that "*In Central America, liberalization appears to have directly influenced*

[25] Ravaillon M. "Looking beyond averages in trade and poverty debate". Wold Dev 2006;34:1374-1392.
[26] Ibidem.
[27] C. Blouin, M. Chopra, R. Van der Hoeven: "Trade and Social Determinants of Health.", in The Lancet, Volume 373, Issue 9662, Pages 502-507, 7 February 2009
[28] Ibidem.

the availability and price of meat and processed foods, many of which are energy-dense and high in fats, sugars and salt". Not surprisingly, these trends were accompanied by rising rates of obesity and chronic diseases such as cardiovascular disease and cancer.[29]

6.2 Loss of government revenues

According to the rules established in Article XXIV of the GATT, under an FTA parties have to liberalize 'substantially all trade'. There is no global consensus on what 'substantially all trade' means, but the EU unilaterally defines this as 90% of trade. Under the EPAs for example, the EU will liberalize 100% of trade whereas the ACP countries are pushed to open up 80% of their markets for European competition in a time frame of 15 years. So ACP states will only be allowed to protect 20% of products from competition with European goods and services.

However, most developing countries are highly dependent on trade taxes (import and export duties) to raise government revenue, as they have limited sources of domestic revenue and limited tax bases. According to World Bank estimates, tariff revenues in sub-Saharan Africa average between 7 and 10 percent of government revenue. With EU products representing 40 per cent of total imports in sub-Saharan Africa, eliminating tariffs on EU imports would lower tariff revenues considerably.[30]

The concerns about the impact that EPA tariff liberalization could have in terms of public revenue losses and how it could exacerbate fragile public budgets in the current complex situation of the financial and economic crisis make the debate about the exclusion list threshold specially relevant and difficult. A study commissioned by ECOWAS on the basis of a 35% exclusion list, suggests that at the end of the liberalization process, annual revenue losses for most countries in the region would be equivalent to between 0.5% and 2% of GDP[31]. In public revenues terms, this translates into losses of 6% for Ghana and Benin and 8% for Togo, which in some cases is higher than the current level of public spending in health or education.[32]

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[29] Anne Marie Thow and Corinna Hawkes: "The implications of trade liberalization for diet and health: a case study from Central America" *Globalization and Health* 2009, **5:**5. Available on http://www.globalizationandhealth.com/content/5/1/5, last accessed on 10 April 2010.

[30] L. Hinkle, M. Hoppe, R. Newfarmer: "*Beyond Cotonou: Economic Partnership* Agreements *in Africa*." In Trade, Doha, and Development - A Window into the Issues; Chapter 22; The World Bank, Trade Department, 2006. Available on http://siteresources.worldbank.org/INTRANETTRADE/Resources/239054-1126812419270/22.BeyondCotonou.pdf, last accessed on 6 April 2010

[31] ECOWAS and UEMOA (2008): "Regional report on identification of sensitive products"

[32] Based on analysis by Ana Candeal and Alejandro Bosch, Universidad Complutense de Madrid, using data from "Regional Report on Identification of Sensitive Products" ECOWAS and UEMOA (July 2008)

A study for the EC contains similar results.[33] Aside from tariff revenue losses, the deals impose additional compliance costs – estimated at a total of €9bn for all ACP countries.[34]

This is why the Globalization Knowledge Network of the Commission on Social Determinants of Health stated that "*high and middle income countries... should not demand further tariffs reductions in bilateral, regional and world trade agreement negotiations with low-income countries still reliant on such tariffs for public revenue, at least until these countries are able to develop alternative methods of revenue collection and the institutional capacity to sustain them*".[35]

For many of the developing countries raising public funds through alternative forms of taxation is not feasible due to their weak formal sectors and the social regressive nature of consumption taxes. Moreover, economists of the International Monetary Fund noted that middle income countries are only likely to recover 45-60% of lost revenue from other taxation sources and low-income countries are at the best likely to recover 30% or less of lost tariff revenue from other taxation sources.[36]

The reaction of a state to such revenue losses may differ. (1) Some countries may cut public spending, putting at risk very much needed funds for the health or education sector. (2) Other states may make use of other forms of taxation, including less equitable taxes such as value-added tax on consumers that impact more heavily on poor households. (3) Revenue loss also pressures a government to transfer the ownership and running of state utilities to both the national and international privatization. So, indirectly, privatization may be encouraged.

Given major supply-side constraints and the possibilities that gains from FTAs will mainly go to large, often foreign-owned companies rather than small local producers, it is not clear that the foregone revenue losses from tariffs will be compensated for by real growth in increased market access.

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[33] Fontagne, L, Mitaritonna, C, Laborde, D. (2008): "An Impact Study of the EU-ACP EPA en the 6 ACP Regions." Available on http://trade.ec.europa.eu/doclib/docs/2008/march/tradoc_138081.pdf, last accessed on 10 April 2010.

[34] C. Milner (2006): "An Assessment of the overall Implementation and Adjustment Costs for the ACP Countries of EPAs with the EU", in R. Grynberg and A. Clarke (2006): " They European Development Fund and Economic Partnership Agreements", Commonwealth Secretariat

[35] Globalization Knowledge Network: "Towards health-equitable globalization: rights, regulation and redistribution. Final report to the commission on social determinants of health." Institute of Population Health. Globalization and Health Equity.

[36] Baunsgaard and Keen (June 2005): *Tax Revenue and (or?) Trade Liberalization,* IMF Working Paper, WP/05/112

6.3 Trade in health and health related services

Health is one of the faster growing sectors in the world economy. In developing countries, it is also increasingly becoming an attractive investment opportunity for private actors due to the growing middle class being able to pay for health services. The consultancy office McKinsey projected the market for private health care in Africa at USD 21 billion a year by 2016[37], which can be earned either by domestic or foreign companies. The recently issued BusinessEurope proposal for trade policy strategy 2014/2020[38] states that the EU needs to address barriers to participation in international public procurement markets in key European sectors such as healthcare and water treatment, through, amongst others, the WTO, FTAs and a reflection on reciprocal market opening,. So it is likely that there will be growing pressure to include health services in trade agreements. We will first discuss the problems related to a growing private sector and then pass to the issues related to making services commitments in binding trade agreements.

6.3.1 Public or private?

By and large, governments have been the major providers of health services for many years. But the situation is changing, notably with the inclusion of private providers of health services. This evolution is being promoted not only through aid policies and policy advice to developing states from rich countries, the IMF and World Bank, but also through the inclusion of commitments in the health sector under GATS and FTAs, by which countries open up their markets for competition to foreign companies. Privatization takes place under several forms, ranging from outsourcing through management contracts to full divestiture of new assets under 30-year concession agreements, sometimes known as public-private partnerships.[39]

However, experience from across developing countries shows that *only governments* can achieve the scale necessary to provide universal access to essential services that are geared to the needs of all citizens and free or heavily subsidized for the poor.

[37] McKinsey&Company (2007): "How private health care can help Africa." Published in The McKinsey Quarterly.

[38] BusinessEurope (2010): Priorities for External Competitiveness 2010-2014: Building on Global Europe. Available on http://extranet.businesseurope.eu/Common/GetFile.asp?docID=25752&logonname=guest&mfd=off . Last accessed on 25/02/2010.

[39] Pollock, A., Price, D.: "The public health implications of world trade negotiations on the general agreement on trade in services and public services." in The Lancet, Vol 362, September 27,2003.

Private providers can make important contributions to the provision of essential services, but only when they are properly regulated and integrated into strong public systems - and not seen as substitutes for them.[40]

In "Blind Optimism", Oxfam shows that more private sector involvement in the health sector will not help to deliver health for poor people. Several arguments have been put forward:

- **Attracting private providers to low-income risky health markets requires significant public subsidy.** In South Africa for example the majority of private medical scheme providers receive a higher subsidy from the government through tax exemption than is spent per person dependent on publicly provided health services.
- **Brain drain:** The private sector may facilitate access to high-level services by the better-off, but it may also divert human resources from public services to more profitable, private services for the elite or foreign markets, thus reducing staffing levels, lowering staff quality and/or raising salary costs for the public sector.
- **Private participation in health care is associated with higher expenditures.** The aim of the private sector is to make profit. Private providers pursue profitable treatments rather than those dictated by medical need. In China, commercialization of health care has led to a decline of less-profitable preventative health care.
- **Private providers generally perform worse on technical quality than the public sector**. In Lesotho, only 37 percent of sexually transmissible infections were treated correctly by contracted private providers, compared with 57 and 96 percent of cases treated in 'large' and 'small' public' health facilities respectively.
- **Private provision can increase inequity of access because it naturally favours those who can afford treatment**. Data from 44 middle-and-low-income countries suggest that higher levels of private-sector participation in primary health care are associated with higher overall levels of exclusion of poor people from treatment and care.
- There is no evidence that private health-care providers are any more responsive or any less corrupt than the public sector.
- **With respect to foreign service providers, they are likely to target only the profitable sectors or the higher income earners.** Consequently not only does the government lose income but it may also be saddled with having to provide the less profitable

[40] Oxfam (2006): "In the Public Interest: Health, Education and Water and Sanitation for All".

service sectors or subsidizing low income earners who cannot afford the prices of foreign service suppliers.

To look to the private sector for the substantial expansion needed to achieve universal access would be to ignore the significant and proven risks of this approach and the evidence of what has worked in successful developing countries. In most low-income countries the high-end and expensive formal private sector is irrelevant for the majority of citizens. Its growth can come at a direct cost to public health systems and undermine their capacity to deliver to those most in need.[41]

6.3.2 Liberalization of services under GATS

Services generally refer to products of human activity aimed at satisfying a human need and does not constitute a tangible commodity.

Under the WTO General Agreement on Trade and Services (GATS), trade in services is regulated within the WTO multilateral trading system. Countries can offer to liberalize trade in services in any of these sectors. That is why we talk about 'commitments'. Of twelve service sectors included in GATS, at least five are directly related to health care systems:

- Business services: Professional services: services of health professionals;
- Distribution services: services in pharmaceutical retailing;
- Education services: Training and education of health professionals;
- Financial services: Health insurance and flows of foreign capital for investment in private hospitals;
- Health and social services sectors: hospital services, medical and dental services, diagnostic services and management of health service facilities.

For a very long time, cross-border trade in services was a very marginal activity. In fact it had to be invented and that is why GATS also describes in detail what is actually meant by trade in services. The agreement distinguishes four different modes by which services can be traded across borders, according to the way they are provided:

1. **Mode 1: Cross Border Supply:** The provision of services that does not involve any physical movement of consumer or service supplier. For example: Telemedicine.
2. **Mode 2: Consumption Abroad:** A consumer leaving their country to consume a service in another WTO country. For example: medical tourism; a Belgian national going to Thailand for surgery.

[41] Oxfam (February 2009): "Blind Optimism: Challenging the Myths about Private Health Care in Poor Countries." Available at http://www.oxfam.org/en/policy/bp125-blind-optimism

3. **Mode 3: Commercial Presence**: Provision of a service through setting up commercial presence, typically through foreign direct investment in the territory of another WTO Member. For example: A Belgian hospital in Jamaica.
4. **Mode 4: Presence of natural persons:** Temporary migration of employees of a company to another country. For example: Philippine nurses working in a hospital in Belgium.

To open up a service sector means that a country can no longer limit the investments of foreign companies, nor the kind of services, unless it explicitly says so during the negotiations and the limitations and conditions are put in the body of the agreement.

A country can make limitations on market access and national treatment:

- Complete market access means no limitations on the number of providers, the numbers of services provided, the value of the imported services, the legal form of the service providers, the participation of foreign capital.
- Complete national treatment means that if a country liberalizes trade and services, it has to allow foreign companies in the country and treat them as local companies. All measures affecting services must be at least equally favourable to foreign service suppliers and services as they are to local suppliers and services. This limits regulatory space for the receiving country.

Although the health sector is one of the faster growing sectors in the world economy, it is one of the least committed sectors under GATS, owing to sensitivities inherent in trading in health services. As at 2005, only 52 out of 137 Members at that time (counting EC 12 as one) had undertaken commitments on hospital services. Many large developed countries like Canada, Switzerland, Norway, Finland and Sweden have not undertaken any type of commitment in the health sector, with Canada making it clear that it will not undertake any access obligation on health services in whatever international forum. These countries prefer to determine the pace and nature of any market opening within reversible domestic policies.

The following table shows the main risks and opportunities related to trade in health services:

	Opportunity	Risk
Mode 1: Cross-border supply	Increased care to remote and under-served areas	Diversion of resources from other health services
Mode 2: Consumption abroad	Much-needed foreign exchange earnings for health services	Crowding out of population and diversion of resources to service foreign nationals
Mode 3: Commercial presence	Opportunities for new employment and access to new technologies	Development of a two-tiered health system with an internal brain-drain
Mode 4: Presence of natural persons	Economic gains from remittances of health-care personnel working abroad	Permanent outflows of health personnel, with loss of investment in educating and training such personnel.

Adapted from World Health Organization, 2006[42]

6.3.3 Liberalization of services under FTAs

The liberalization of health services under FTAs follows the same logic as under the GATS. As is the case in the GATS, countries are not obliged to make commitments in the health sector. However, in the FTAs there is an additional pressure on countries to do this as, according to Article V of GATS, the agreement should have substantial sectoral coverage, expressed in terms of sectors, volume of trade affected and modes of supply. The EU has not yet put a threshold on 'substantial sectoral coverage' but officials have already said that it is likely to do so in the future.

If we look to the Cariforum example (Annex 2), we can see that all these countries have made considerable commitments in the health sector in mode 1, 2 and 3. Mode 4 remains in all countries unbound, except for key personnel and graduate trainees not available locally. Under the GATS few of these countries had opened up the health sector for foreign competition. Some voices argue that the Cariforum countries have chosen to open up their health sector to European competition in the hope to

[42] World Health Organization, Regional Office for Africa: Poverty, Trade and Health: An emerging health development issue. Report of the regional officer. 17 June 2006. Available on http://www.afro.who.int/rc56/documents/afr_rc56_9_poverty_trade_health_final.pdf, Last accessed on 07 January 2010.

develop medical tourism in the region, following the example of Thailand.

6.3.4 Health liberalization: Locking-in commercialization

Making services commitments is by nature complex and mistakes are made – even by rich countries. Making a commitment to liberalize trade in services under a free trade agreement is very different from undertaking liberalization unilaterally within one country's own policy framework. A trade commitment is binding and irreversible. Without a trade commitment, a country has the freedom to open up services sectors and change regulations as appropriate to development needs. If things go wrong, governments could change their minds. Under a trade commitment however, foreign investors will be able to invoke trade dispute resolution processes if denied access to a country's domestic market. So trade agreements are not the cause of today's health care privatization, but they 'lock in' current levels of privatization and can prevent any future expansion (or re-creation) of the public system. In that sense health commitments in trade agreements complement the World Bank's support for the privatization of health care in low-income and middle-income countries, including through subsidized loans to private corporations.[43]

Governments may want to experiment with commercialization in some components of their health systems, but making these policy experiments part of binding trade treaties will strongly limit their ability to undo these reforms if they wish to do so in the future.[44] Service commitments effectively undermine the flexibility of governments to regulate – including in a discriminatory manner – against foreign firms. Opening up services without proper regulation can run the risk of leaving poor or remote communities without key services.[45]

6.4 Access to Medicines

In developing countries, where health insurance is scant and most health services are paid out-of-pocket, prices of medicines and diagnostic procedures are a critical factor in determining the level of health care. The high cost of medicines in developing countries reduces access, both by limiting the ability of governments to expand coverage and by limiting the ability of poor people to pay for medicines out-of-pocket. The current patent system (and other forms of intellectual property protection) delays competition by low-cost competitors, resulting in higher prices of medicines.[46]

[43] D. Legge, D. Sanders, D. McCoy (2009): "Trade and health: the Need for a Political Economic Analysis". In The Lancet, Volume 373, Issue 9663

[44] Globalization Knowledge Network: "Towards health-equitable globalization: rights, regulation and redistribution. Final report to the commission on social determinants of health." Institute of Population Health. Globalization and Health Equity.

[45] Oxfam (2008): "Partnership or Powerplay? How Europe should bring development into its trade deals with Africa, Caribbean and Pacific Countries.

[46] WHO. Public Health, Innovation and Intellectual Property Rights. Commission on

Generic competition makes prices of medicines drop by an average of 40-80% with the first generic entry. As more competitors enter the markets, prices of medicines continue to fall with time. Competition is stimulated between originator and generic companies, and also between generic companies. In any case, competition is key to implementing the vision of access to medicines for all. The protection of intellectual property rights is a barrier to competition and therefore also to access to medicines.

Nearly all countries, with the exception of the European Union, the United States and Japan, are net importers of intellectual property (which broadly includes products and services protected by patents, trademarks, copyrights and trade secrets). Further strengthening of IP protection increases the costs of accessing those goods for citizens of developing countries. On the other hand, if net IP exporters (which are mainly industrialized countries), can obtain broader and longer periods of IP protection, company profits and corresponding market share in developing countries increases (and for a longer duration of time).

Furthermore, increased IP protection also impedes developing countries from establishing their own pharmaceutical industry. India, for example, did not provide product patent protection for pharmaceuticals until 2005, allowing the country (in particular from 1970) to develop a thriving pharmaceutical industry that both imitates and copies. In general, most developed countries crossed the technology boundary into innovation through imitation – IP protection in rich countries was introduced at far higher levels of economic development than it has been introduced in developing countries in recent years.

In March 2009, the UN Special Rapporteur on the Right to Health, Mr Anand Grover noted the use of TRIPS flexibilities has been variable and that there are growing instances of developing countries and least developed countries adopting TRIPS-plus (IP rules that exceed minimum obligations under TRIPS) standards that may have an adverse affect on the right to health. He therefore highlighted the need to revisit trade-related agreements in light of their impact on the right to health and in particular on access to medicines. He concluded that "*developing countries and LDCs should not introduce TRIPS-plus standards in their national laws. Developed countries should not encourage developing countries and LDCs to enter into TRIPS-plus FTAs and should be mindful of actions which may infringe upon the right to health*."[47]

Intellectual Property Rights, Innovation and Public Health (CIPIH). Geneva, WHO, 2006.

[47] Office of the High Commissioner for Human Rights. http://www2.ohchr.org/english/bodies/hrcouncil/docs/11session/A.HRC.11.12_en.pdf, last accessed on 10 April 2010.

6.4.1 TRIPS

The TRIPS Agreement of the WTO mandated the introduction of protection of intellectual property rights, notably patents, for pharmaceutical products, while also introducing a comprehensive regime for the protection of other forms of IP (including other forms of patent protection, copyright and trademarks). TRIPS requires WTO Members to provide protection for a minimum term of 20 years from the filing date of a patent application for any invention including for a pharmaceutical product or process. Prior to the TRIPS Agreement, patent duration was significantly shorter or even non-existent in many countries. The TRIPS Agreement also requires countries to provide patent protection for both processes and products, in all fields of technology.

The TRIPS Agreement provided for transition periods, permitting developing countries additional time to bring national legislation and practices into conformity with TRIPS provisions. Most developing countries were allowed to delay providing product patent protection in the areas of technology that had not been so protected at the time of the TRIPS Agreement until 2000. Some countries, and crucially India (as well as Egypt) were given a transition period until 2005. Least-developed countries were granted a longer transition period until 2006, with the possibility of an extension. For pharmaceutical patents, this has been extended to 2016, under a decision taken by the Council for TRIPS in 2002.[48]

The TRIPS Agreement includes several flexibilities that allow the governments of developing countries in principle to defend the interests of their constituencies. Because of the difficulties in the implementation of these flexibilities, the developing countries brought the issue back on the table of the WTO in Doha. Hence the 2001 Doha Declaration on TRIPS and public health allows WTO members to interpret TRIPS in a manner supportive of their efforts to protect public health and promote access to medicines. It reiterates the right of member countries to use the flexibilities, including[49]:

- providing for compulsory licensing or the right to grant a license. Compulsory licensing enables a competent government authority to license the use of a patented invention to a third party or

[48] World Trade Organization (2002), Decision of the Council for TRIPS of 27 June 2002: Extension of the Transition Period under Article 66.1 of the TRIPS Agreement for Least-Developed Country Members for Certain Obligations with Respect to Pharmaceutical Products. Available on http://www.wto.org/english/tratop_E/trips_e/art66_1_e.htm, Last accessed on 02 February 2010.

[49] Aulline H. Mabika, Percy F. Makombe, Ludwig Chizarura, Rene Loewenson: Health implications of proposed Economic Partnership Agreement (EPA) between east and southern African countries and the European Union. SEATINI, TARSC, EQUINET, Discussion Paper 41, February 2007.

government agency without the consent of the patent-holder. The Doha Declaration states that each Member has the right to grant compulsory licenses and the freedom to determine the grounds upon which such licenses are granted.
- Providing for parallel importation or the right to import products patented in one country from another where the price is less.
- Exceptions from patentability and limits on data protection.

The full use of TRIPS flexibilities can help countries meet their obligations to protect, promote and fulfil the right to health by improving access to affordable medicines. However, the use of TRIPS flexibilities has been variable and many countries do not make use of these flexibilities because of red tape and political pressure.[50] In other cases, developing countries have introduced TRIPS-plus rules, which either circumscribe the use of flexibilities or fully negate such flexibilities and safeguards.

6.4.2 The EU's new approach to Intellectual Property Rights

In recent years, the EU has been promoting very tough provisions regarding the protection of intellectual property rights. Since 2004, the EU has identified and classified different categories of countries, according to their implementation of IPR protection. Meanwhile, the EC is increasing its human resources allocated to supervising enforcement of intellectual property rights in third countries, affecting positions to specific places identified as key (such as Bangkok, Beijing, and Moscow).[51]

6.4.3 Intellectual Property Rights in FTAs

A common feature of the FTAs that the EU is concluding with third countries is that they include so-called TRIPS-plus standards. This means that they require the protection of intellectual property rights that go beyond what was internationally agreed upon in the TRIPS Agreement. Studies indicate that TRIPS-plus standards increase medicine prices as they delay or restrict the introduction of generic competition. For example:

Patent term extension – Under the TRIPS Agreement, patents must last for 20 years from the date of application. FTAs can oblige the partner signatory countries to respect patents for longer periods of time.

Data exclusivity – The TRIPS Agreement requires WTO members to

[50] Jacqui Wise. Access to AIDS medicines stumbles on trade rules. Bull World Health Organ 2006, 84(5), pp. 342-344.

[51] Xavier Seube, H. (2009), "Health Protection in the New Association Agreement Between the Andean Community (or some of its members) and the European Community in the Light of its Provisions Concerning Intellectual Property and Recent Experiences", HAI Europe & AIS LatinoAmerica and Caribe, January 2009. Available at: http://www.haiweb.org/20012009/19%20Dec%202008%20Policy%20Paper%20EU-CAN%20Association%20Agreement%20(Final%20EN).pdf, last accessed on 10 April 2010.

protect undisclosed test data on pharmaceutical products against unfair competition. Many FTAs, however, enhance the protection for clinical data by providing up to 11 years of exclusive use of such data. This effectively prolongs monopoly protection for medicines as competitors cannot make use of this data.

Criminal sanctions - The TRIPS Agreement was already novel - internationally speaking - when introducing criminal sanctions for infringements of certain IP rights. However, it limited those sanctions to cases of copyright piracy and trademark counterfeiting and allowed the exclusion of imprisonment among the criminal sanctions. By contrast, the European proposal to the Andean Community made the punishment of all intellectual property rights infringements mandatory through, among other sanctions, imprisonment. But what it is more striking is that these very standards have been explicitly rejected domestically by European countries and also by the European Parliament.

Border measures - The TRIPS only made it mandatory for the right holder to lodge an application to customs authorities to suspend the release of imported counterfeit trademark or pirated copyright goods into free circulation. By contrast, the European proposal to ACTA enables the right holder to block the importation, exportation, or transit of goods suspected of infringing any intellectual property rights in the customs territory. This would internationalize EC Directive 1383/2003 under which in the past year there have been several seizures at customs of legitimate generic medicines which were on their way from India to other developing countries. This represents a dramatic broadening of the required measures and grants a tremendous power to title holders who will be able to block rival goods alleging a supposed infringement of an IP right. Customs officials would be able to impound legally produced generic medicines, in effect becoming the protector of private commercial interests.

Compulsory adherence to IPR-treaties: Typically, the FTAs also oblige countries to adhere to international IPR treaties.

In short, the FTAs tend to benefit the pharmaceutical monopolies and impede access to medicines in the countries that sign up to the agreements. Recently, MSF, Oxfam International and Health Action International therefore released a joint statement stating that "European Union trade policies consistently threaten access to affordable essential medicines by seeking to entrench overreaching intellectual property rules."[52]

By negotiating these kind of provisions, the EU ignores the resolution of the European Parliament of 2007, which "*calls on the Council to meet its*

[52] MSF, Oxfam International and Health Action International joint statement. Trading Away Access to Medicines: How the European Commission's Trade Agenda has taken an wrong Turn. October 2009.

commitments to the Doha Declaration and to restrict the Commission's mandate so as to prevent it from negotiating pharmaceutical-related TRIPS-plus provisions affecting public health and access to medicines, such as data exclusivity, patent extensions and limitation of grounds of compulsory licences, within the framework of the EPA negotiations with the ACP countries and other future bilateral and regional agreements with developing countries."[53]

For example, in the negotiations on the EU-CAFTA and EU-CAN Association Agreement, the EU demanded far reaching TRIPS-plus measures with regards to data exclusivity and stricter intellectual property enforcement.[54] [55] According to studies conducted by Bogota-based IFARMA and Health Action International (HAI), the acceptance of the European proposal on IP protection in the EU-CAN FTA would cost the Colombians approximately 750 million USD annually. The impact studies on Colombia found that patent extension and data exclusivity provisions proposed by the EU would mean that the number of medicines on the market under patent would rise from approximately 8% to 21% of all the products on the market. The EU's proposals on patent protection and data exclusivity would increase the prices of medicines by up to 34 percent. Five million Colombians and more than six million Peruvians would lose access to affordable medicines by 2030 unless public health budgets of those countries were increased by US$280 million and US$250 million respectively.[56] [57]

Meanwhile, the EU is also involved in the negotiations for an Anti-Counter-feiting Trade Agreement (ACTA). These started in June 2008 between the EU, United States, Switzerland, Australia, Japan, Canada, South Korea, Mexico, Morocco and New Zealand. ACTA aims to develop and implement a multilateral IP enforcement scheme, focusing on international coopera-

[53] European Parliament Resolution (2007): TRIPS Agreement and access to medicines , available on http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P6-TA-2007-0353+0+DOC+XML+V0//EN, last accessed on 26 February 2010

[54] Health Action International (2010): Access to Medicines in Jeopardy: Central America in negotiations wit the EU. Policy Brief

[55] Cronin D.(2010): Tough IP health provisions in Europe's Colombia/Peru trade deal, available on http://www.ip-watch.org/weblog/2010/02/25/tough-ip-health-provisions-in-europes-colombiaperu-trade-deal/, last accessed on 10 April 2010

[56] Oxfam International and Health Action International. EU Commission pushes its trade agenda on Andean nations despite public health consequences. June 16, 2009, available on http://www.haiweb.org/19062009/16%20Jun%202009%20Joint%20Press%20release%20Commission%20pushes%20its%20trade%20agenda%20on%20Andean%20nations.pdf, last accessed on 10 April 2010.

[57] Health Action International (2009): Impact of the EU-Andean Trade Agreements on Access to Medicines in Peru. Available on http://www.haiweb.org/11112009/ReportIFARMAImpactStudyPeru%28EN%29.pdf, last accessed on 26 February 2010

tion, enforcement practices and a legal framework that contains proposed provisions on enforcement, which are very similar to EC demands in its bi-lateral and regional agreements. The parties aim to conclude the agreement by the end of 2010. All negotiation parties refuse to release the texts to public scrutiny.[58] One danger is that the provisions of ACTA will be considered as standards that have to be applied by all nations – and will be enforced through new trade agreements, unilateral pressure or trade-offs for other trade benefits at the multi-lateral level.[59]

[58] Oxfam International and Health Action International: Trading Away Access to Medicines: How the European Commission's Trade Agenda has taken an wrong Turn. October 2009, available on http://www.oxfam.org/en/policy/trading-away-access-medicines, last accessed on 10 April 2010.

[59] Impact of IP provisions from EC draft trade agreement with ASEAN on access to medicines. Jiraporn Limpananont, Gaëlle Krikorian, *FTA Watch, Bangkok,* 21 Feb 2009.

7. Conclusion and Recommendations

"*Trade impacts on the right to health in numerous ways*", said Paul Hunt, the first United Nations Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, in 2004. He added that "*States have to ensure that the trade rules and policies they select are consistent with their legal obligations in relation to the right to health*."

It is therefore appropriate to scrutinize trade agreements for their impact on public health. Free trade agreements between a powerful trading block like the European Union and developing countries have an impact on a number of issues, including health. It goes without saying that the economies and populations of the developing countries are more vulnerable to potential impacts.

It is particularly worrisome therefore that trade agreements are negotiated behind closed doors. The European Commission neither informs nor consults relevant stakeholders from civil society. Not even the European Parliament is updated about the status of the negotiations. Interestingly, corporate lobby groups seem to have more access to the negotiators. Only when a trade pact is forged are its provisions submitted to public scrutiny.

Since the multilateral trade negotiations under the World Trade Organisation became deadlocked because of the South's resistance to more liberalization, the European Union has started bilateral trade negotiations with a number of developing countries, individually or in group. The free trade agreements the European Union wants to clinch are going beyond the provisions of the WTO agreements.

Incoming Trade Commissioner Karel De Gucht enthusiastically said in January 2010 that "*bilateral agreements can go further and faster in promoting openness and integration, by tackling issues which are not ready for multilateral discussion and by preparing the ground for the next round of multilateral negotiations."* He likewise acknowledged that "*many key issues (...) which are currently insufficiently covered by the WTO, can be addressed in such agreements."*

De Gucht seems to take it for granted that more and faster liberalization also serves the interest of the peoples of the South. We are not convinced. We believe there are reasons for concern as our research warned us of some dangerous threats to the people's right to health.

As the European Union is prioritizing its own commercial interests, trade liberalization has serious consequences on food security, employment and

incomes in the South, all of which have a tremendous impact on public health.

The abolition or lowering of tariffs on cross-border trade also means less income for developing countries. As they represent a significant proportion of government revenues in the poorest countries, this would seriously restrain their capacity to implement social policies, which, in turn, has an impact on health.

The trade agreements the European Union is currently negotiating also comprise clauses on the liberalization of trade in services, including health care. This encourages commercialization and privatization of health services in developing countries and makes them irreversible. Nevertheless, a strong public sector is essential to guarantee health care for all.

The European Union is also keen on negotiating agreements with strong provisions on the protection of intellectual property rights. These provisions go beyond those of the TRIPS Agreement under the World Trade Organization even though it has been recognized that this agreement has had a detrimental impact on access to medicines in developing countries.

The Belgian Platform for Action and Solidarity is therefore calling on social movements and NGOs to put pressure on the European Commission to stop giving priority to commercial interests. The right to health should be a primary concern. Hence the need to take it into account in the European trade policies.

In these matters of life and death, we urge the European Commission to respect at least the following principles:

- **Clear criteria:** There have to be clear criteria which trade policies have to respect in order to avoid a negative impact on public health. These criteria have to be decided by the European Parliament after public debate with the participation of relevant stakeholders from civil society.

- **Transparency:** Trade agreements should not be negotiated in secrecy. The European Parliament and all relevant stakeholders, including social movements, have to be informed about the progress of the negotiations.

- **Prior impact studies:** Before trade agreements are signed, there should first be independent impact studies that look into potential consequences of these agreements on public health. The results of these studies should be made public before the ratification of the trade agreements.

- **Nothing is forever:** After trade agreements come into effect, their impact on public health has to be monitored continuously. If negative impacts on health become apparent, it should be possible to amend the agreement in question.

- **Do not harm:** Provisions that are obviously bad for public health, including TRIPS-plus provisions and the liberalization of health services, should never be part of free trade agreements. Moreover, the EU should provide compensation for any loss of government revenues by the developing countries arising from the agreement.

8. Annex 1: The Example of the Cariforum EPA

8.1 Health situation in Cariforum

The health status in the Caribbean can be considered to be good according to health indicators but the challenge is to sustain the current health status and to continuously improve health in an environment of new threats, globalization, increasing cost and mounting demands. Within the Cariforum there is not much difference in the health trends and the chief causes of death (mortality) and disease (morbidity) are mainly commonly shared. Exceptions are Haiti and Guyana that struggle with higher rates of infant mortality and HIV/AIDS. These two countries also have the lowest life expectancy in Cariforum. The average life expectancy in Cariforum is comparable to the average of the other Latin American countries but lower than the Northern American countries (Bermuda, Canada and USA).

In general, the Caribbean countries are disadvantaged with respect to their small size and small economies that limit resources and investments. Moreover, the Caribbean's vulnerability to natural phenomena such as flooding and hurricanes not only places a strain on the economies and health sectors but also slows down development and causes setbacks.

The main challenges for the health sector remain in **infrastructure** and **halting the migration of health personnel**. Proper health provision requires an infrastructure that is available throughout the country with equitable access for all to illness prevention and treatment. In some Cariforum countries the infrastructure is not available everywhere, especially in countries with a hinterland and large rural areas (e.g. Jamaica). On the other hand, in the smaller countries, because of the low population, specific, specialized services are usually not available. Most Caribbean countries should be able to provide good quality primary and prevention health services but there is a trend for infrastructure to decline in the Caribbean.
The region is also challenged by shortages of health personnel, especially in smaller countries. The standard of work is low and there are problems retaining trained personnel, especially nurses. The Caribbean loses about 300 nurses per year. Factors that influence organization, management, and financing in order to improve equitable access in health are the relatively high poverty rates in the Caribbean and the existence of a large informal sector. The government usually pays for the poor and a large part of the informal sector. Private health expenditure is high in Trinidad and Tobago, Jamaica and the Bahamas whereas government expenditure is high in Dominica, Grenada, Saint Kitts, Barbados and Saint Lucia, Saint Vincent and Antigua.

8.2 Liberalization of health services under Cariforum

Health services are regulated under Title II: Investment, Services and E-Commerce. The main objective of Title II is to establish enforceable rights to foreign investors and service firms. These rights often contradict the aspirations stated in other parts of the EPA.
Title II severely restricts the right of governments on how to regulate. Regulation may only be 'to meet legitimate policy objectives', but legitimate is not defined. Title II excludes 'services supplied in the exercise of governmental authority', but this only covers services that are neither commercial nor competing with another provider or investor. Very few public services today meet those criteria. As many of the essential public services may not be eligible for exclusion, foreign service providers will probably be able to access public interest sectors such as water, health and education. As said before, these providers are likely to cherry pick only the most profitable sectors or the higher income earners. The 'governmental authority' exception also says no commitment should be construed to require the privatization of a public enterprise. But privatization these days takes many forms that do not involve the sale of an asset or enterprise. Examples include public-private partnerships or simply opening a public service to competition. Moreover, the disciplines under Title II are supported by enforcement mechanisms in the EPA. These disciplines are expected to take precedence over a country's national considerations and objectives when there is a conflict. From article 62 we learn that this 'final' comprehensive EPA is only the first stage of a process of ongoing negotiations between CARIFORUM and the EC for the liberalization of investment and cross border supply of services. Another negotiating round must begin within 5 years. The revision clause of the Caribbean EPA is aimed at 'broadening and supplementing' the scope of the agreement and does not provide for modifications on the grounds of adverse impacts on development. Any modifications to the agreements have to be jointly agreed upon by Europe and the ACP. This means it will be extremely difficult for Caribbean countries to modify services regulations in future in line with their evolving development needs.

The service liberalization schedules of the Bahamas and Haiti are not known yet, but most of the other 13 countries have made considerable commitments in the health sector in modes 1, 2 and 3. Mode 4 remains 'unbound' in all countries, except for key personnel and graduate trainees not available locally. Only Barbados made very few commitments. The Dominican Republic makes the important horizontal commitment that FDI is prohibited in activities that are likely to affect public health, but afterwards it still makes considerable liberalization commitments under modes 1, 2 and 3. In the GATS few of these countries had opened up the health sector to foreign competition. The general limitation attached to the service schedule is: "*this schedule of commitments cannot be construed as offering in any way the privatization of public undertakings nor as pre-*

venting any Signatory CARIFORUM State from regulating any sector or economic activity in order to meet national policy objectives". However, we have already seen the problem with this statement.
It also has to be noted that there are several errors and inconsistencies in the services schedule, which afterwards may be open for discussion. For example, Grenada states that for medical and dental services limitations on market access in modes 1 and 2 are both 'none' and 'unbound'.

8.3 Example of health schedule: Jamaica

Jamaica has made some horizontal commitments limiting the scope of service liberalization in general. For example, Mode 4 is unbound, except for key personnel and graduate trainees not available locally. This means Jamaica does not make any commitment under the movement of persons, with the exception of key personnel and graduate trainees not available locally. In this way Jamaica still protects the local labour force.
Jamaica also placed an important limitation on national treatment with regards to public services, stating that "eligibility for government funding or subsidies is limited to Jamaican entities and to services considered in the public interest. With regard to health, educational and environmental services, as well as other services considered in the public interest, government benefits, scholarships, government loans and grants are limited to Jamaican citizenship and or resident in Jamaican according to the relevant immigration legislation, and may be tenable and/or utilized only at non-profit public and publicly funded institutions in Jamaica." This is an important limitation safeguarding public services. For example, scholarships could still be used by the Jamaican government to encourage the use of public schools. However, Jamaica and Belize are the only two countries introducing this limitation.

With regards sectoral commitments, we can see that Jamaica is opening up her health market considerably to European competition under mode 1, 2 and 3 (cross-border supply, consumption abroad and commercial presence). When we see a 'none', this means there are no limitations; complete market access and national treatment is given, as long as horizontal commitments are taken into account. So for example, under mode 2 a Jamaican national can go to a doctor in Europe and if he/she has the right to reimbursement for treatment in Jamaica, he/she will also have to be reimbursed for treatment in Europe. Under mode 3, hospital services, Europeans can establish hospitals in Jamaica without limitations. They will not be subject to an economic needs test and it will be very difficult for the Jamaican government to determine in which places the hospital should be established. The same is true for Catscan, a very expensive service whose use and location a government will generally try to limit and regulate (for example, only one Catscan per province). Jamaica will not be able to do any of these.

Sectoral commitments	Mode	Limitations on Market Access	Limitations on National Treatment
A. Professional Services			
1. Medical and Dental Services (CPC[60] 9312)			
except CPC 93123 (dental services)	1	none	none
	2	none	none
	3	none	none
	4	unbound, except as indicated in horizontal commitments	unbound, except as indicated in horizontal commitments
2. Neurosurgery			
	1	none	none
	2	none	none
	3	none	none
	4	unbound, except as indicated in horizontal commitments	unbound, except as indicated in horizontal commitments
3. CATSCAN services			
	1	none	none
	2	none	none
	3	none	none
	4	unbound, except as indicated in horizontal commitments	unbound, except as indicated in horizontal commitments
4. Services provided by mid-wives, nurses, physiotherapists and paramedical personnel (CPC93191)			
	1	none	none
	2	none	none
	3	none	none
	4	unbound, except as indicated in horizontal commitments	unbound, except as indicated in horizontal commitments
B. Health Related and Social Services			
1. Hospital Services (CPC 9311)			
	1	none	none
	2	none	none
	3	none	none
	4	unbound, except as indicated in horizontal commitments	unbound, except as indicated in horizontal commitments
2. Other human health services (CPC9319 other than 93191) (nursing services, ambulance services, medical laboratory services,…)			

[60] For an explanation on CPC (Central Product Classification) : http://unstats.un.org/unsd/cr/registry/cpc-2.asp

	1	none	none
	2	none	none
	3	none	none
	4	unbound, except as indicated in horizontal commitments	unbound, except as indicated in horizontal commitments
3. Social Services cpc 933			
cpc 9331, 93324	1	none	none
	2	none	none
	3	none	none
	4	unbound, except as indicated in horizontal commitments	unbound, except as indicated in horizontal commitments

8.4 Intellectual Property provisions in Cariforum

The Cariforum EPA contains TRIPS plus measures which will have consequences for access to medicines in these countries. For example, the countries are obliged to join the Patent Cooperation Treaty (PCT), which is designed to enable people to apply for a patent in multiple countries easily. It does this by standardizing the application procedures and requiring PCT Parties to accept the standardized procedure. Making it easier to apply for a patent, a developing country can expect more patent applications after joining the PCT. [61]

[61] Third World Network (2009): EU EPAs: Economic and Social Development Implications: the case of the CARIFORUM-EC Economic Partnership Agreement. Available on www.twnside.org.sg/title2/par/**CARIFORUM**.Feb09.doc , last accessed on 26 February 2010.

9. Annex 2: Overview of ongoing FTA negotiations between the EU and (groups of) developing countries

Name of the agreement	Countries concerned	Start of the negotiations	Status of the negotiations	Provisions related to services	IP provisions
Cariforum EPA	Antigua & Barbuda, Bahamas, Barbados, Belize, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Saint Lucia, Saint Vincent, Saint Christopher & Nevis, Surinam, Trinidad & Tobago	2004	Completed, signed in October 2008	Most countries have done considerable commitments towards the liberalization of services, including in the health sector.	The agreement contains several TRIPS plus provisions.
Central Africa EPA	Cameroon, Central African Republic, Chad, Congo (Brazzaville), Congo (Democratic Republic),	2003	Interim EPA[62] signed with Cameroon. Negotiations continue to achieve a	Under negotiation.	Under negotiation.

[62] An interim EPA is an agreement which only contains the liberalization of goods. The final aim of the EU is to reach so called 'full EPAs' in all the different regions, which also contains the liberalization of services and government procurement, plus provisions on competition policy and intellectual property rights.

	Equatorial Guinea, Gabon and São Tomé and Príncipe		regional EPA.		
SADC region EPA	Angola, Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland and Tanzania.	2004	Interim EPA signed with Botswana, Lesotho, Swaziland and Mozambique (Namibia pending). Negotiations continue to reach a full regional EPA.	Under negotiation.	Under negotiation.
West Africa EPA	Benin, Burkina Faso, Cape Verde, Gambia, Ghana, Guinea, Guinea Bissau, Ivory Coast, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone and Togo	2003	Individual interim EPAs signed with Ivory Coast and Ghana. Negotiations continue to achieve regional EPA.	Under negotiation.	Under negotiation.
EAC EPA	Kenya, Uganda, Tanzania, Rwanda and Burundi.	2007	Interim EPA concluded but still to be signed. Negotiations	Under negotiation.	Under negotiation.

			continue to achieve regional EPA.		
Eastern and Southern Africa (ESA) EPA	Comoros, Djibouti, Eritrea, Ethiopia, Malawi, Mauritius, Madagascar, Seychelles, Sudan, Zambia and Zimbabwe.	2004	Interim EPA signed with Madagascar, Mauritius, Seychelles and Zimbabwe. (Comores and Zambia pending). Negotiations continue to achieve regional EPA.	Under negotiation.	Under negotiation.
The Pacific EPA	Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Nauru, Niue, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.	2004	Interim EPA with Papua New Guinea and Fiji signed. Negotiations continue to achieve regional EPA.	Under negotiation.	Under negotiation.
EU-ASEAN FTA	Brunei Darussalam, Cambodia, Indonesia, Laos,	2007	Negotiations proceeded slowly and are on a	The EU insists on the inclusion of services.	The EU demands TRIPS-plus measures with regard to data

	Malaysia, Burma/Myanmar, Philippines, Singapore, Thailand and Vietnam.		pause since March 2009. Now the EC has a mandate to continue negotiations for comprehensive FTAs wit individual ASEAN countries, starting with Singapore and Vietnam.		exclusivity, patent-term extension and stricter intellectual property enforcement, including border measures.
EU-CAN Association Agreement	Bolivia, Colombia, Ecuador and Peru.	2007	Negotiations with Colombia and Peru are concluded since March 2010. Signature foreseen in May 2010. Bolivia and Ecuador suspended their participation in June 2007.	The EU insists on the inclusion of services.	The EU demands far reaching TRIPS-plus measures with regards to data exclusivity and stricter intellectual property enforcement.
EU-Central America Association Agreement	Panama, Guatemala, Costa Rica, El Salvador, Honduras,	2007	Ongoing. To be signed in May 2010.	The EU insists on inclusion of professional services in the agreement.	The EU demands far reaching TRIPS-plus measures with regards to extension of patents,

	Nicaragua				data protection and stricter intellectual property enforcement.
EU-Mercosur FTA	Argentina, Brazil, Paraguay, Uruguay andVenezuela.	2000	Negotiations are stalled since 2006. They were revived by the Spanish EU presidency in February 2010.		
EU-India FTA	India	2007	Ongoing.	The framework agreement for the India-EU bilateral pact suggests liberalising commitments in all modes of services including cross-border movement of services, consumption of services abroad and cross-border movement of people.	The EU demands TRIPS-plus measures with regards to data exclusivity, patent-term extension (to 25 years) and stricter intellectual property enforcement.

Sources: various articles on http://bilaterals.org and http://ec.europa.eu/trade/creating-opportunities/bilateral-relations/

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