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Calibrating the Wealth and Health of Nations: Trade, Health, and Foreign Policy After the WTO's First Decade

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ABSTRACT

One of the most important themes to emerge from the relationship between trade and health in the first ten year's of the WTO's existence is the challenge of achieving policy coherence. This task is a foreign policy challenge for WTO Members, which requires looking at the relationship between trade and health against the backdrop of the making and implementing of foreign policy. Policy coherence has generally become a major concern for foreign policymakers because post-Cold War trends, such as accelerating globalization, seriously challenge traditional foreign policy assumptions, practices, and institutions. Part of this new context for foreign policy involves the rise of health as a foreign policy issue. The trade-health relationship in the WTO is embedded, thus, in a broader range of policy coherency questions affecting all the governance functions served by foreign policy.

Considered against these broader frameworks, policy coherence concerning trade and health breaks down into external and internal contexts. External policy coherency considers the extent to which States balance their national interests in trade and health in their anarchical interactions. This balancing analysis focuses attention on rules of international law, such as WTO agreements, which States have devised to calibrate their national interests in trade and health. Internal policy coherency examines whether States have domestically organized their policymaking to ensure that both trade and health sectors contribute synergistically

to the formulation of the national interest. As between external and internal policy coherency, more effort by States is required internally; and the article proposes an approach called "trade epidemiology" to foster better internal policy coherency.

Improving policy coherency for trade and health externally and internally faces, however, significant obstacles, including the possibility that more pressing foreign policy, trade, and health problems subordinate the trade-health coherence objective on the foreign policy agendas of States.

KEYWORDS: *policy coherency; foreign policy; public health; World Trade Organization; World Health Organization*

I. INTRODUCTION: THE IMPORTANCE OF POLICY COHERENCY AFTER TEN YEARS OF TRADE AND HEALTH WITHIN THE WORLD TRADE ORGANIZATION

The tenth anniversary of the World Trade Organization (WTO) in 2005 served as the occasion for many reflections on the past, present, and future of the WTO.[1] Given the broad impact of the WTO on international relations in an era characterized by economic globalization, the reflections on the WTO's first decade ranged across many issues and subject areas. Many of the reflective analyses on the WTO's first decade did not expressly consider the relationship between trade and the protection of human health.[2] This relationship has, however, become significant in terms of the WTO's role in the governance of world politics. The focus of this *Journal* recognizes, for example, the interdependence of trade and health in the early 21st century. For the inaugural issue of the *Journal,* this article focuses lessons learned about on the relationship between trade and health during the first ten years of the WTO's operations.

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[1] *See, e.g.,* PETER SUTHERLAND ET AL., THE FUTURE OF THE WTO: ADDRESSING INSTITUTIONAL CHALLENGES IN THE NEW MILLENNIUM (2005) [hereinafter THE FUTURE OF THE WTO].

[2] *Id.*

The relationship between trade and health within the WTO is multifaceted and has been the topic of often acrimonious controversies. A few examples provide a sense of the diversity and intensity of the trade and health debate. Global civil society groups have criticized various WTO agreements, especially the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)[3] and the General Agreement on Trade in Services (GATS),[4] for the adverse impact they have, or could have, on the ability of WTO Members to protect and promote the health of their populations. Aware of the fierce debates over the WTO's impact on public health, the WTO and the World Health Organization (WHO) engaged in an unprecedented joint study of the WTO agreements and public health.[5] WTO Members have also utilized the WTO Dispute Settlement Body to resolve cases involving trade-restricting measures justified on health protective grounds, with *US–Gasoline*,[6] *EC–Hormones*,[7] and *EC–Asbestos*[8] being (as of this writing[9]) the most well-known cases involving the trade and health relationship. Health has also been raised as an issue with respect to plans to liberalize trade in agricultural products because of concerns that such liberalization could damage food security in developing countries.[10]

The range of health-related issues and controversies that have arisen concerning trade in the last decade demonstrates that health cuts comprehensively across the WTO agreements. Organizing an analysis of the past ten years of the health and trade relationship in the WTO proves, therefore, a daunting undertaking. My approach in this article does not engage in an agreement-by-agreement or case-by-case analysis of the manner in which WTO rules handle the overlap in trade and health

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[3] Agreement on Trade-Related Aspects of Intellectual Property Rights, Apr. 15. 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, *in* WORLD TRADE ORGANIZATION, THE LEGAL TEXTS: THE RESULTS OF THE URUGUAY ROUND OF MULTILATERAL TRADE NEGOTIATIONS 321–353 (1999) [hereinafter TRIPS].

[4] General Agreement on Trade in Services, Apr. 15. 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1B, *in* WORLD TRADE ORGANIZATION, THE LEGAL TEXTS: THE RESULTS OF THE URUGUAY ROUND OF MULTILATERAL TRADE NEGOTIATIONS 284–319 (1999) [hereinafter GATS].

[5] WORLD HEALTH ORGANIZATION AND WORLD TRADE ORGANIZATION, WTO AGREEMENTS & PUBLIC HEALTH: A JOINT STUDY BY THE WHO AND THE WTO SECRETARIAT (2002) [hereinafter WTO AGREEMENTS & PUBLIC HEALTH].

[6] Appellate Body Report, *United States – Standards for Reformulated and Conventional Gasoline*, WT/DS2/AB/R (May 20, 1996) [hereinafter *US – Gasoline*].

[7] Appellate Body Report, *European Communities – Measures Concerning Meat and Meat Products (Hormones)*, WT/DS26/AB/R, WT/DS48/AB/R (Feb. 13, 1998) [hereinacter *EC – Hormones*].

[8] Appellate Body Report, *European Communities – Measures Affecting Asbestos and Asbestos-Containing Products*, WT/DS135/AB/R (Mar. 12, 2001) [hereinafter *EC – Asbestos*].

[9] The preliminary panel report in another important health-related case under the Agreement on the Application of Sanitary and Phytosanitary Measures, *EC – Biotech Products*, was issued to the parties to the dispute in February 2006 but had not, at the time of this writing, been issued publicly.

[10] WTO AGREEMENTS & PUBLIC HEALTH, *supra* note 5, at 125–126 (discussing trade liberalization and food security).

objectives. Instead, I look to what many believe has been, is, and will continue to be the central challenge of this relationship – achieving policy coherency between trade and health.

A resolution passed by the WHO Executive Board in January 2006 demonstrates the centrality of the policy coherency challenge in the trade and health relationship. The WHO Executive Board recommended that the World Health Assembly stress "the need for all relevant ministries, including those of health, trade, commerce, finance and foreign affairs, to work together constructively in order to ensure that the interests of trade and health are appropriately balanced and coordinated[.]"[11] The Executive Board recommended that the World Health Assembly urge WHO Members "to create constructive and interactive relationships across the public and private sectors for the purpose of generating coherence in their trade and health policies[.]"[12] In addition, the Executive Board advised the World Health Assembly to request that the WHO Director-General provide support to WHO Members in connection with "their efforts to frame coherent policies to address the relationship between trade and health"[13] and to continue collaborations with other international organizations "in order to support policy coherence between trade and health sectors at regional and global levels, including generating and sharing evidence on the relationship between trade and health[.]"[14]

The WHO Executive Board's interest in trade and health policy coherency reflects the deeper importance policy coherency has developed as an objective over the first decade of the WTO's operations. The WHO-WTO joint study on the WTO agreements and public health concluded its analysis by stressing the need for policy coherence. The WHO and WTO noted:

> There is common ground between health and trade. . . . Yet concerns have been expressed by some observers that WTO rules constitute a threat to sound public health policies. . . . A constructive way to address such concerns is to view them as opportunities for finding common ground. Minimizing possible conflicts between trade and health, and maximizing their mutual benefits, is an example of policy coherency. The term refers to efforts to seek synergies between policies in different areas in support of their common goals – in this case, poverty reduction, human development and economic growth. . . . [T]his report

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[11] WHO Executive Board, *International Trade and Health*, WHO Doc. EB117.R5, Jan. 25, 2006, preamble.
[12] *Id.* ¶ 1(4).
[13] *Id.* ¶ 2(1).
[14] *Id.* ¶ 2(3).

> stresses the importance of the goal of coherence between health and trade policies at the national and international level.[15]

The growing importance of policy coherence between trade and health within the WTO raises questions and problems at different levels of policy formulation and implementation. As the WHO and WTO observed, "[p]olicy coherence is easy to support in principle but hard to achieve in practice."[16] The complexity inherent in creating coherence for trade and health policies requires looking at specific problems, such as access to pharmaceuticals and trade in health services, the politics of which have been controversial, especially from the health perspective. Specific issues arise, however, within larger contexts that are also important to understand in contemplating the task of crafting of policy coherence. This article focuses on policy coherence issues concerning trade and health in international trade law under the WTO from the broader perspective of trade and health as converging foreign policy issues.

The task of coordinating trade and health policies is only one example of coherence questions facing foreign policy generally in many countries. Changes in international relations, especially since the end of the Cold War, have forced all countries, even the most powerful, to confront challenges and problems for which their traditional policy assumptions, practices, and institutions have proved ill equipped. The policy coherence agenda is, thus, much larger than both the specific trade and health relationship and the more general set of contentious "trade and . . ." debates.[17] The article explains why understanding this larger phenomenon is important in analyzing policy coherence between trade and health in the international trade law contained within the WTO.

Part of post-Cold War adjustments foreign policymakers have made involves the rise of health as a foreign policy issue. The linkage of trade and health as policy coherency subjects cannot be isolated from the manner in which health has emerged as an important challenge across the range of objectives countries pursue with their foreign policies. Health's contemporary importance to the key areas of foreign policy makes the task of policy coherence between trade and health more important and more complicated, especially if the professed objective of the coherency exercise is human development.

Approaching the policy coherence challenge between trade and health in the WTO from the general perspective of foreign policy and the specific

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[15] WTO AGREEMENTS & PUBLIC HEALTH, *supra* note 5, at 137–138.

[16] *Id.* at 138.

[17] The "trade and . . ." debates involved arguments about linkages between international trade law in the WTO and other policy objectives, including foreign investment, competition law, environmental protection, labor standards, and human rights.

perspective of health's rise as a foreign policy concern produces the need to analyze coherence in two contexts: (1) *external policy coherence*, which involves the balancing of the interests of different States in trade and health through international law and diplomacy; and (2) *internal policy coherence*, which involves getting trade and health to work together more effectively in the State's formulation of the national interest. The article explores each of these aspects of policy coherence, identifies internal policy coherence as the more difficult and pressing challenge, and sketches a framework for promoting improved internal policy coherence.

The article's final substantive section briefly reviews obstacles that may complicate and frustrate the achievement of policy coherence between trade and health in international trade law. These obstacles arise from foreign policy generally, health's rise as a foreign policy concern, trade and health in their own rights, and from trade developments that affect the pursuit of external and internal policy coherence.

II. COHERENCY AND FOREIGN POLICY: THE CHALLENGE OF NETWORKED ANARCHY

The effort to focus on coherency with respect to trade and health in the WTO is but one example of a much larger project underway in government ministries around the world. This project arises from the need, noted inside and outside the halls of power, to rethink foreign policy in order to enable countries to respond more effectively to the challenges they face in 21st century world politics. In general terms, the impetus to re-invent foreign policy flows from awareness that post-Cold War geopolitical changes, technological developments, and the acceleration of globalization render ineffective foreign policy assumptions, practices, and institutions developed in a different time for a different set of priorities.

A high profile example, the 9/11 attacks on the United States, illustrates the changing contexts in which foreign policy must now be made. As the 9/11 Commission argued, the United States foreign policy and national security communities failed conceptually and institutionally to "connect the dots" populating the policy landscape that indicated a major terrorist attack was in the works.[18] For many reasons, ranging from conceptual myopia to institutional inertia, the U.S. government had not achieved coherence on anti-terrorism policy and capabilities before 9/11. Since that horrible day, U.S. policymaking communities have been struggling to achieve such policy coherence.

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[18] NATIONAL COMMISSION ON TERRORIST ATTACKS UPON THE UNITED STATES, THE 9/11 COMMISSION REPORT (2004).

A. Three Trends Fostering the Rethinking of Foreign Policy

Reinventing foreign policy confronts three trends that simultaneously call for, and complicate, coherency approaches. The first trend is the breakdown between the traditional distinctions between "domestic policy" and "foreign policy." This trend is familiar to those who work on public health because it has been a theme in the literature on the globalization of public health with respect to both communicable and non-communicable diseases. [19] The trend is not, however, confined to public health, as confusion in the United States and other countries between "homeland security" and "national security" makes clear. Increasingly, policy problems are "global" and only with difficulty can they be categorized as "domestic" or "foreign."[20]

The second trend is for problems to cut across conventionally defined issue areas, creating the need for "interagency" cooperation and coordination within governments. [21] Such problems do not respect traditional jurisdictional boundaries that establish turf for government ministries. As explored below, the emergence of health as a foreign policy issue constitutes just such a cross-cutting challenge. More specifically, concerns about how trade and health policies align also express the need to adapt vertically "stove piped" ministries to horizontally dynamic problems.

The third trend arises from the convergence of the other two trends. As "stove piped" government ministries and agencies increasingly have to manage globalized issues, they begin to interact more directly with their counterparts in ministries overseas. Such transgovernmentalism produces what scholars call the disaggregation of State sovereignty.[22] The formation of transgovernmental networks at ministry level and below undermines the notion that a unitary State makes and implements policy. Rather, transgovernmental networks influence how policy is made. Horizontal plumbing connecting the policy nodes of disaggregated States is replacing the vertical stove piping of policy in the unitary State.

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[19] Kelley Lee, Suzanne Fustukian & Kent Buse, *An Introduction to Global Health Policy, in* HEALTH POLICY IN A GLOBALISING WORLD 3, 3–17 (K. Lee, K. Buse & S. Fustukian eds., 2002).

[20] David Held and Anthony McGrew, *Political Globalization: Trends and Choices, in* PROVIDING GLOBAL PUBLIC GOODS: MANAGING GLOBALIZATION 185–199 (I. Kaul, P. Conceição, K. Le Goulven & R. U. Mendoza, eds., 2003).

[21] JOSPEH S. NYE & ANNE MARIE SLAUGHTER, PRINCETON PROJECT ON NAT'L SEC., REPORT OF THE WORKING GROUP ON FOREIGN POLICY INFRASTRUCTURE AND GLOBAL INSTITUTION (2005), available at http://www.wws.princeton.edu/ppns/conferences/reports/fall/FPIGI.pdf.

[22] ANNE-MARIE SLAUGHTER, A NEW WORLD ORDER (2004).

B. Implications of the Three Trends for Policy Coherence

Each trend has important consequences for thinking about policy coherence. The blurring of the traditional distinction between domestic and foreign policies actually increases the importance of foreign policy for all issue areas. The interconnectedness between the local and the global fostered by globalization produces the need to shift governance of issues from the local to the national, and from the national to the global. The essence of foreign policy – organizing a country's relations with other States and foreign bodies – has increasingly become central to most policy areas. As a result, coherence in foreign policy has wide ramifications as a governance matter.

The tendency of globalized problems to affect policy across traditionally defined issue areas creates not only the need for interagency efforts but also competition among agencies for how the interagency agenda should unfold. The question becomes not policy coherence per se but policy coherence on whose terms. Interagency cooperation and coordination can trigger darwinistic, survival-of-the-fittest behavior, with "alpha agencies" protecting their bureaucratic turf and attempting to expand that turf at the expense of less powerful agencies.

The rise of transgovernmentalism as a policy phenomenon complicates the State's production of coherent policy. Horizontal policy plumbing among finance ministers of various countries might achieve coherence among themselves, but they might fail to connect their pipes with the plumbing running between development or environment ministries. To overcome the potential policy incoherence resulting from the formation of transgovernmental networks, these networks have to be networked themselves so that a "network of networks" strives for policy coherence. The complexity of the task of policy coherence in such an approach perhaps makes interagency cooperation within a single government look simple by comparison.

C. Policy Coherence in Networked Anarchy

This discussion of the three trends and their implications assumes that policy coherence is, or should be, a central characteristic of foreign policy in a globalized world. We should pause to consider this assumption because it connects to divergent perspectives about the ultimate purpose of a country's foreign policy. We might agree that policy coherence is important to a State's foreign policy for the reasons explored above, but this consensus tells us little about *why* a particular State might think coherence is an important national interest. The demand for policy coherence may have nothing to do with promoting human development

nationally or globally but everything to do with a State's interests in security, power, or placating an influential special interest group.

Exploring diverse explanations about the nature of foreign policy is beyond this article's scope, but a few words are in order because some elements of the debates about foreign policy are important for thinking about policy coherence generally and with respect to trade and health in the WTO. At its most basic, foreign policy represents a State's attempt to secure its interests in a political environment characterized by anarchy. Anarchy does not mean chaos. Rather, anarchy describes the fact that international relations operate in a political context in which the actors recognize no common, superior authority.[23] The condition of anarchy affects, however, State behavior, especially foreign policy. Different theories of international relations offer competing explanations for the underlying motives of foreign policy behavior.

All leading theories of foreign policy behavior would explain any drive for policy coherence in terms of larger objectives connected to a country's concept of its national interests. Policy coherency, in the abstract, does not motivate States unless it serves some political purpose. States interacting in a condition of anarchy often have conflicting conceptions of what is important in their national interests. Country A and Country B may be pursuing coherency in their respective foreign policies on the same issues but for reasons that conflict. Each may achieve policy coherency but not develop a foundation for successful collective action on a particular problem.

In other words, coherency in one State's foreign policy does not necessarily produce collective coherency among countries. States compete to maximize the likelihood that their own conceptions of coherence prevail. Depending on the configuration of power among States, one could see the hegemon or a small circle of great powers determine what policy coherency means. Anarchical politics are rarely representative or democratic.

This dynamic of competition often brings intergovernmental institutions and mechanisms, including international law, into play. States use these instruments to coordinate divergent national interests and to mediate power inequalities in the international system. In these settings, policy coherency among countries often becomes the search for the lowest common denominator, or for rhetoric sufficiently broad to allow every State to claim it obtained what it wanted from the multilateral process. The outcome of the World Summit at the United Nations in September 2005 provides an example of these lowest-common denominator politics.[24]

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[23] Tim Dunne & Brian C. Schmidt, *Realism*, *in* THE GLOBALIZATION OF WORLD POLITICS: AN INTRODUCTION TO INTERNATIONAL RELATIONS 141, 143 (J. Baylis & S. Smith eds., 2nd ed. 2001).
[24] UN General Assembly, *World Summit Outcome*, UN Doc. A/60/L.1, Sept. 20, 2005.

The picture is more sobering when one combines the impact of anarchy with the effects of globalization. Anarchy pushes countries to decide on negotiating positions and strategies that represent their national interests. The mechanics of globalization disaggregate issues and policy responses, fostering more complex webs of transgovernmental networks that make the national interest appear kaleidoscopic. From the foreign policy perspective, coherence has to be pursued in the context of networked anarchy, a political context that requires unity of purpose implemented through a diversity of means. Policy coherence in networked anarchy requires the ability, nationally and globally, to synthesize cross-cutting problems and to re-wire internal and external networks to produce actions that adequately address them. This ability indicates that States must have sufficient governance capacity to undertake these tasks.

III. THE COHERENCY CHALLENGE OF HEALTH AS FOREIGN POLICY

Exploring the general challenges policy coherence faces in the world of foreign policy is important to understanding the policy coherency agenda involving trade and health. The trade and health coherency challenge highlighted by the first ten years of the WTO's existence should be seen as only part of the broader enterprise of integrating health into all major functions of foreign policy. This enterprise emerged in the last decade as health increasingly became more important to many aspects of countries' foreign policies.[25] Health's rise as a foreign policy issue enhances and complicates the objective of producing coherency in trade and health policies in the WTO.

A. Foreign Policy's Governance Functions

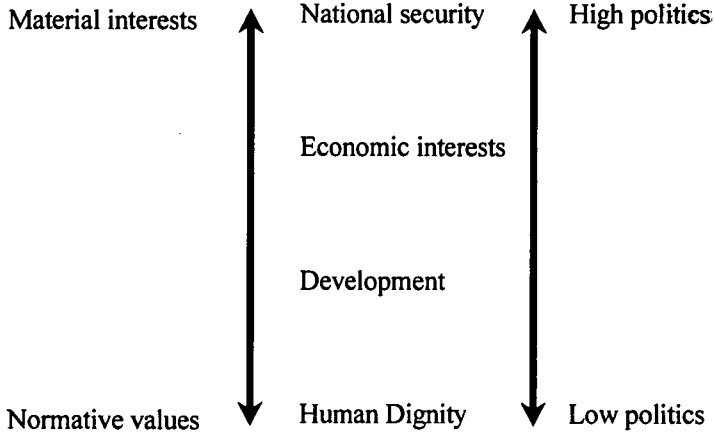
In simple terms, States undertake four governance functions through foreign policy. First, States attempt to ensure their security from external threats. Historically, this function has focused on military threats posed by rival States. Second, States engage in foreign policy to enhance their economic power and well-being. Thus, trade and foreign investment strategies play a significant role in foreign policies. Third, States support the political and economic development of other countries. Often the foreign policy concern about development connects to the State's security or economic interests, but sometimes States undertake development initiatives for humanitarian reasons. Fourth, States use foreign policy to promote and protect human dignity, as evidenced by support for human

[25] *See, e.g.*, HEALTH, FOREIGN POLICY & SECURITY: TOWARDS A CONCEPTUAL FRAMEWORK FOR RESEARCH AND POLICY (A. Ingram, ed., 2004); David P. Fidler, *Health as Foreign Policy: Between Principle and Power*, 6 WHITEHEAD J. DIPL. & INT'L REL. 2, 179–194 (2005).

rights and the provision of humanitarian assistance to countries and populations.

Historically, these foreign policy functions existed in a hierarchy. Security and economic power ranked as more important than development and human dignity. See Figure 1. From the mid-19th century until World War II, foreign policy's interest in health predominantly concerned reducing the burden national health measures, such as maritime quarantine, imposed on international trade and commerce.[26] Since World War II, health's place in foreign policy mostly related development and human dignity agendas, the traditional "low politics" of international relations.

FIGURE 1.[27]



Even in these agendas, health was not a top priority. The approach of development policies to health during the Cold War stressed that "wealth produced health." The argument that investments in health actually contribute to economic development did not gain serious influence until the

[26] David P. Fidler, *From International Sanitary Conventions to Global Health Security: The New International Health Regulations*, 4 CHINESE J. INT'L L. 325, 328–33 (2005) (analyzing the international law and diplomacy concerning control of the international spread of infectious diseases from 1851 to 1951).

[27] DAVID P. FIDLER, HEALTH AND FOREIGN POLICY: A CONCEPTUAL OVERVIEW 3 (2005).

World Bank published *Investing in Heath* in 1993.[28] In terms of human dignity, the bifurcation of human rights into civil and political rights and economic, social, and cultural rights put health into the latter category,[29] which did not receive as much attention as civil and political rights from human rights advocacy during the Cold War. Further, WHO's approach to international health after its establishment in 1948 moved away from the pre-World War II foreign policy linkage of the health and trade interests of States and towards achieving universal access to primary health care in the developing world.[30] This "health for all" strategy was not directly connected with the specific trade interests of States. The strategy was linked to trade more generally through its support for the New International Economic Order,[31] which sought to restructure radically all manner of international economic relations.[32]

B. Health as Foreign Policy

The rise of health as a foreign policy issue during the last decade reveals health escaping from its traditional place in the "low politics" of international relations to a situation in which health has become an important consideration for each of the governance functions foreign policy serves. The public health threats posed by biological weapons and pandemic diseases have become national and international security concerns.[33] The emphasis by both the WTO and WHO on the importance of trade and health coherency signals the emergence of health as a more important consideration in international economics, a message reinforced by other efforts.[34] In terms of development, WHO has pointed out that health is at the heart of the United Nations' Millennium Development Goals (MDGs),[35] which constitute the leading development initiative in the world today. Rights-based arguments involving health proliferated in the

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[28] WORLD BANK, WORLD DEVELOPMENT REPORT 1993: INVESTING IN HEALTH (1993).

[29] *See* International Covenant on Economic, Social, and Cultural Rights art. 12, Dec. 16, 1966, 993 UNTS 3 (on the right to the highest attainable standard of health).

[30] Declaration of Alma Ata, International Conference on Primary Health Care, Sept. 6–12, 1978, available at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf.

[31] *Id.*

[32] Declaration and Programme of Action on the Establishment of a New International Economic Order, G.A. Res. 3201–3202 (May 1, 1974); Charter of Economic Rights and Duties of States, G.A. Res. 3281 (Dec. 12, 1974).

[33] *See, e.g.*, HEALTH, FOREIGN POLICY & SECURITY: TOWARDS A CONCEPTUAL FRAMEWORK FOR RESEARCH AND POLICY (A. Ingram, ed., 2004).

[34] *See* COMMISSION ON MACROECONOMICS AND HEALTH, INVESTING IN HEALTH FOR ECONOMIC DEVELOPMENT (2001).

[35] World Health Organization, *WHO and the Millennium Development Goals*, available at http://www.who.int/mdg/en/.

last decade, including concerns about HIV/AIDS-related discrimination,[36] ensuring civil and political rights are protected as much as possible when governments respond to outbreaks of dangerous communicable diseases (e.g., quarantines used during the SARS outbreak in 2003),[37] and increasing access of the poor and vulnerable to essential medicines.[38]

These developments across all the governance functions of foreign policy forced governments to think about health as foreign policy. Whether and how health is integrated effectively across the foreign policy functions have now become important national and international governance questions. The rise of health as a foreign policy concern exhibits all the characteristics of networked anarchy analyzed above – the blurring of traditional distinctions between domestic and foreign policy, the tendency of health problems to cut across traditionally defined issue areas, and the development of transgovernmental and non-governmental networks trying to address health problems. The idea of *health as foreign policy* attempts to capture the challenge of crafting unity of purpose on health challenges through the diversity of functions served by foreign policy. Health as foreign policy requires coherence not only within individual foreign policy functions but also across these functions.

The idea of health as foreign policy does not mean that foreign policies of different countries are or will be uniform as to whether or how they integrate health for foreign policy purposes. The health component of security is more important to the United States because of bioterrorist fears than it is for many developing countries, which perhaps focus more on health's role in their development. Developed States may stress their sovereign right to establish "zero tolerance" levels for health risks potentially moving in international trade, but this high level of health protection may adversely affect developing-country exports that cannot achieve the high level of health protection established. In addition, the extent to which a State can pursue health as foreign policy depends on its governance capacities, which raises questions about the governance capabilities of many developing and least-developed countries.

Thus, health as foreign policy does not escape the effects anarchy has on States' calculations of their respective national interests. Divergence of national interests among States routinely occurs in international relations. To ameliorate such divergence, a State will often argue that its interests coincide with what is in the interest of other States and the international

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[36] LAWRENCE O. GOSTIN, THE AIDS PANDEMIC: COMPLACENCY, INJUSTICE, AND UNFULFILLED EXPECTATIONS (2004).

[37] MARK A. ROTHSTEIN ET AL., QUARANTINE AND ISOLATION: LESSONS LEARNED FROM SARS, A REPORT TO THE CENTERS FOR DISEASE CONTROL AND PREVENTION (2003).

[38] *See* Medecins sans Frontieres, *Campaign for Access to Essential Medicines*, available at http://www.accessmed-msf.org/.

community. This "harmony of interests" doctrine has been criticized in connection with foreign policy behavior generally,[39] and the doctrine is equally suspect in the context of health and foreign policy.

For example, developed States (and pharmaceutical companies) have argued that high international standards for protecting pharmaceutical patents and other forms of intellectual property are good for the world's health because such protection will stimulate more health-related research and development. Many developing States and non-governmental organizations (NGOs) have met claims that a harmony of interests exists among States on the need for high levels of patent protection with skepticism and opposition. This example illustrates that, even within health as foreign policy, the national interest rather than abstract notions of human development controls and shapes the political context in which States pursue policy coherency.

IV. TRADE AND HEALTH AS A COHERENCY CHALLENGE IN FOREIGN POLICY

Approaching the challenge of policy coherence between trade and health in the WTO from foreign policy generally and health as foreign policy specifically produces the need to give coherence more precise meaning. To understand the challenge properly, we need to comprehend that coherence can exist at two different levels – the external and the internal. External coherence refers to policy coherence in the international realm, in the anarchical space in which States interact. Internal coherence means policy coherence in the domestic realm, in the hierarchical space in which countries respectively organize their political affairs. External and internal coherence are interdependent, but they are sufficiently different analytically to be discussed as separate aspects of the larger task of policy coherence.

A. External Policy Coherency: Balancing State Interests in Trade and Health

As argued above, the dynamics of anarchical politics among States often produces divergent national interests. Some controversy and concern that have arisen in the trade-health relationship in the WTO flow from a perceived divergence of national interests on trade and health issues. Country A wants to increase exports of tobacco products, but Country B wants to restrict importation of tobacco products in order to protect public

[39] EDWARD H. CARR, THE TWENTY YEARS' CRISIS, 1919–1939: AN INTRODUCTION TO THE STUDY OF INTERNATIONAL RELATIONS 75–85 (2nd ed.1946) (critiquing the harmony of interests doctrine).

health. Country C wants to increase access to effective medical technologies by producing them locally, but Country D wants Country C to respect the patent rights on such medical technologies held by Country D's nationals. Country E wants to increase its exports of private health insurance services, but Country F wants to prevent private insurance from undermining the universal coverage provided by its national health insurance system.

As with all issues in international relations, the main question when national interests diverge is how States manage this divergence in their anarchical relations. In this external policy realm, continued divergence of national interests will prevent construction of collective approaches that accommodate differing national interests in sustainable patterns of behavior. Achieving such accommodations produces external policy coherence when divergent interests are balanced, meaning that the outcome allows States to hold and pursue both interests simultaneously.

Balancing trade and health interests has been an objective of both international law on public health and international trade law well before the WTO's establishment. Both sets of international legal rules have long recognized a State's right to restrict trade to protect human health, provided that the trade-restrictive measure has a rational relationship to protecting health and does not restrict trade more than is necessary to achieve the health objective in question.

The old international sanitary conventions of the late 19th and early 20th centuries and WHO's International Health Regulations (originally adopted in 1951) prohibited the use of trade-restricting measures designed to prevent the importation of specific communicable diseases unless the conventions or Regulations specifically authorized the use of such measures.[40] These agreements contained the maximum health-protecting measures that States parties could apply to international trade and travel.[41] The General Agreement on Tariffs and Trade (GATT) (originally adopted in 1947) likewise permitted contracting parties to violate GATT obligations if the violating measures were necessary to protect human health,[42] with

[40] Fidler, *supra* note 26, at 329.

[41] *See, .e.g.,* International Sanitary Convention art. 15, June 21, 1926, 2 BEVANS 545 ("The measures provided for in this Chapter must be regarded as constituting a maximum within the limits of which Governments may regulate the procedure to be applied to ships on their arrival."); International Health Regulations art. 23, July 25, 1969, *in* WORLD HEALTH ORGANIZATION, INTERNATIONAL HEALTH REGULATIONS (1969) (3rd ann. ed. 1983) ("The health measures permitted by these Regulations are the maximum measures applicable to international traffic, which a State may require for the protection of its territory against the diseases subject to the Regulations.").

[42] General Agreement on Tariffs and Trade, art. XX(b), Apr. 15. 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1A, *in* WORLD TRADE ORGANIZATION, THE LEGAL TEXTS: THE RESULTS OF THE URUGUAY ROUND OF MULTILATERAL TRADE NEGOTIATIONS 423–492 (1999) [hereinafter GATT].

"necessary" meaning that the measure in question had to be the least GATT-inconsistent (i.e., least trade-restrictive) measure possible to achieve the health protection sought.[43] This approach, common to both pre-WTO international law on public health and trade, attempted to establish a balance between one State's interest in engaging in trade and another State's interest in protecting the health of its population.

B. External Policy Coherency on Trade and Health and International Law

Contemporary international law on public health and international trade law within the WTO continue to attempt to balance trade and health interests and thus achieve external policy coherency. First, in terms of trade in goods and health, the key WTO agreements – GATT, the Agreement on the Application of Sanitary and Phytosanitary Measures (SPS Agreement),[44] and the Agreement on Technical Barriers to Trade (TBT Agreement)[45] – recognize the WTO Member's right to restrict trade to protect human health but apply disciplines to this right to ensure that trade is not unnecessarily restricted and health is not used to disguise an unjustified or arbitrary restriction on international trade.

With regard to international law on public health, the same approach of balancing the right of health protection with preserving as much trade flow as possible has routinely appeared from the international sanitary conventions of the late 19th century to the new International Health Regulations adopted in 2005 (IHR 2005).[46] For example, the IHR 2005's purpose and scope "are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade."[47] The stability and continuity of this approach over long periods of time in both international trade law and international health law suggest that States have

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[43] *Thailand – Restrictions on Importation of and Internal Taxes on Cigarettes*, Nov. 7, 1990, GATT Doc. DS10/R. GATT B.I.S.D. (37th Supp.) at 200 (1991).

[44] Agreement on the Application of Sanitary and Phytosanitary Measures, Apr. 15. 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1A, *in* WORLD TRADE ORGANIZATION, THE LEGAL TEXTS: THE RESULTS OF THE URUGUAY ROUND OF MULTILATERAL TRADE NEGOTIATIONS 59–72 (1999) [hereinafter SPS Agreement].

[45] Agreement on Technical Barriers to Trade, Apr. 15. 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1A, *in* WORLD TRADE ORGANIZATION, THE LEGAL TEXTS: THE RESULTS OF THE URUGUAY ROUND OF MULTILATERAL TRADE NEGOTIATIONS 121–142 (1999) [hereinafter TBT Agreement].

[46] World Health Assembly, *Revision of the International Health Regulations*, WHA58.3 (May 23, 2005) [hereinafter IHR 2005].

[47] *Id.* art. 2.

settled on a strategy they believe produces sustainable external policy coherency between trade in goods and health.

Second, in terms of trade in health-related services, the main multilateral agreement, GATS, imposes few disciplines on WTO Members seeking to protect health from potentially adverse effects created by imports of health-related services.[48] GATS' general obligations, such as the most-favored-nation principle,[49] are not a serious constraint on the exercise of sovereignty to protect human health. In terms of specific commitments under GATS, each WTO Member decides whether it wants to accord market access or national treatment to the health-related services and service providers of other WTO Members, subject to whatever exceptions to such access and treatment the WTO Member desires to retain.[50]

Unlike the SPS Agreement and the TBT Agreement,[51] GATS contains no general obligation to ensure that any trade-restricting health measure is not more restrictive than necessary to achieve the health objective in question. This obligation appears is GATS' general exceptions, which allow WTO Members to violate GATS in implementing a measure that is necessary to protect human health and that is not applied in a manner that constitutes arbitrary or unjustified discrimination against trade.[52] The balance struck for external policy coherency with respect to GATS allows WTO Members to favor health over trade much more compared to the agreements on trade in goods.

Third, with respect to intellectual property rights, TRIPS requires WTO Members to accord baseline patent rights,[53] subject to safeguards and flexibilities that WTO Members can use for public health purposes.[54] This approach echoes the one taken in trade in goods – the rules allow an exception to general obligations that can be used for health protection purposes. The Doha Declaration on the TRIPS Agreement and Public Health (Doha Declaration) issued at the Doha ministerial meeting in 2001 made clear that nothing in TRIPS should be interpreted to prevent a WTO Member from taking action to protect health.[55]

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[48] *See generally* DAVID P. FIDLER, CARLOS CORREA & OBIJIOFOR AGINAM, LEGAL REVIEW OF THE GENERAL AGREEMENT ON TRADE IN SERVICES (GATS) FROM A HEALTH POLICY PERSPECTIVE (2005); David P. Fidler, Nick Drager, Carlos Correa & Obijiofor Aginam, *Making Commitments in Health Services under the GATS: Legal Dimensions, in* INTERNATIONAL TRADE IN HEALTH SERVICES AND THE GATS: CURRENT ISSUES AND DEBATES 141, 141–167 (C. Blouin, N. Drager & R. Smith eds., 2006).

[49] GATS art. II.

[50] *Id.* arts. XVI, XVII.

[51] SPS Agreement art. 5.6; TBT Agreement art. 2.2.

[52] GATS art. XIV.

[53] TRIPS arts. 27–28.

[54] *Id.* art. 31.

[55] World Trade Organization, *Declaration on the TRIPS Agreement and Public Health*, WT/MIN(01)/DEC/2 (Nov. 20, 2001), at http://www.wto.org/English/thewto_e/minist_e/min01_e/mindecl_trips_e.htm [hereinafter *Declaration on the TRIPS Agreement and Public Health*].

C. Criticism of the Prevailing External Policy Coherency in International Trade Law

To be sure, many health experts and advocates would argue that international trade law as developed over the first decade of the WTO's operations favors trade over health and thus does not achieve the balance required for external policy coherency. The requirement that trade-restricting health measures be necessary – the so-called "necessity test" – has been a particular target of health-related criticism of WTO agreements. According to such critics, a more coherent approach would be to permit all trade-restricting health measures that had a legitimate basis and were applied in a non-discriminatory manner. The "necessity test" allows scientifically justified and non-discriminatory measures to be struck down to facilitate larger trade flows.

GATS' seemingly more flexible approach to trade in services has also not been well received in many health policy circles because of fears that GATS will lead to the privatization of public services, harming efforts to achieve, for example, universal access to health care.[56] Similarly, concerns have been raised about TRIPS' requirement that all countries provide baseline patent rights for all pharmaceutical products, subject only to safeguards and flexibilities that major economic players, particularly the United States, have challenged and tried to undermine. Many critics of TRIPS would prefer to leave the decision about what kind of patent rights recognize the sovereign deliberations of each country, an approach that would allow each country to accommodate its health concerns more robustly if it so desired. The Doha Declaration arose from intense controversy on the meaning and scope of the safeguards and flexibilities TRIPS contains and does not reflect solidarity in terms of external policy coherency on the relationship between patent rights and public health.

The common thread in these criticisms is that the WTO rules create an imbalance rather than a balance because the rules favor trade over health, and thus do not achieve external policy coherency. The criticisms help demonstrate, however, that external policy coherency involves balancing competing national interests. This balancing task does not, and cannot, strive for calibrating competing interests such that both get equal weight in all situations. Anarchical politics rarely produce results where everything is accorded equal weight. Further, rules that gave equal weight to all competing interests would produce deadlock because such rules provide no guidance for deciding when one interest should legitimately prevail other another in case of conflict.

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[56] Fidler et al., *supra* note 48, at 143.

D. External Policy Coherency Scorecard for Trade and Health after Ten Years of the WTO

1. External Policy Coherency and Trade in Good.— A case can be made that the existing WTO rules, with the exception of the patent provisions in TRIPS, adequately balance trade and health interests and thus achieve external policy coherency. As noted above, the prevailing international legal rules in the WTO concerning trade in goods and services construct approaches that permit trade flows and health protection to occur in a sustainable pattern over time.

Health critics of WTO rules on trade in goods still dislike the potential that trade interests can trump health concerns and would prefer rules that they accorded greater deference to sovereign decisions on protecting health. This alternative vision of external policy coherency is not, however, realistic or feasible. My argument relies less on a detailed reading of the existing WTO rules than on an emphasis of the importance of trade to international relations, especially in the post-Cold War era.

Health as foreign policy is a relatively new phenomenon. Trade as foreign policy is as old as international relations itself. The interests of States in being able to trade robustly are pervasive. Globalization grooves these interests more deeply with each passing year. Contemporary economic growth and development strategies depend on the engine of trade. Trade could even be considered a geopolitical determinant of health that requires the support and backing of public health as a matter of foreign policy. A weak or failing international trading system would produce political and economic consequences under which national and global health, especially of the most vulnerable populations, would suffer. Public health needs a stable, orderly, and dynamic international trading system because this system delivers economic opportunities and resources that are critical for improving standards of living and funding public services. This reality applies to developed and developing countries and thus is not confined to contexts of development.

Given the enormous geopolitical importance of trade, and its foreign policy significance to every country, the international trade law in the WTO on goods and services actually accommodates health well, especially considering the fact that health officials and experts were not significantly involved in the negotiations of the WTO agreements. The appearance time and again of the same template for balancing trade and health with respect to trade in goods in international trade law and international law on public health also suggests that the competing interests of States have found equilibrium that works. The template's appearance again in the IHR 2005 reinforces its systemic stability.

2. External Policy Coherency and Trade in Services. — For services, the template is currently whatever the WTO Member in question wants the balance between trade in services and the protection of health to be. Proposals made in advance of, and during, the WTO ministerial meeting in Hong Kong in December 2005 would, if adopted, have significantly changed the status quo. Under proposals made before the Hong Kong ministerial meeting, WTO Members would have to make mandatory, numerically based liberalization commitments across service sectors. Many WTO Members opposed these numerical targets for the services negotiations. In November 2005, the Chairman of the Council for Trade in Services reported:

> A number of Members stated that numerical targets would help to translate a high level of ambition into meaningful commitments for services in the round. Several Members indicated that inclusion of numerical targets in the text of the Ministerial Declaration would be necessary. Many Members expressed strong reservations about numerical targets, particularly in terms of their compatibility with the GATS and the Negotiating Guidelines, and considered that these proposals were no longer a basis for discussion. Given that the gap between positions remains too wide to be bridged, I have not included a reference to numerical targets in the draft text [for the Hong Kong ministerial meeting].[57]

Disputes about moving negotiations on liberalization of trade in services from the bilateral request-offer format into a plurilateral request-offer mechanism also caused problems in pre-Hong Kong discussions in the Council on Trade in Services. Plurilateral requests would involve WTO Members making offers or requests to a number of other WTO Members simultaneously with the view to collective negotiations the results of which would be made available to all WTO Members on a most-favored-nation basis. The Chairman of the Council on Trade in Services reported in November 2005 that "regarding negotiations on a plurilateral basis, a number of delegations felt that the text could have been phrased in a more binding manner. Other Members took the opposite view that certain of its elements were overly prescriptive." [58] Despite the disagreement about plurilateral negotiations, the draft text for the Hong Kong ministerial

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[57] Council for Trade in Services, *Special Session of the Council for Trade in Services: Report by the Chairman to the Trade Negotiations Committee*, ¶ 9, TN/S/23 (Nov. 28, 2005).
[58] *Id.* ¶ 13.

meeting included language that required WTO Members engage in the plurilateral process.[59]

At Hong Kong, WTO Members did not include numerical targets in the services annex of the Ministerial Declaration but did include the non-binding option for WTO Members to engage in plurilateral negotiations on liberalization of trade in services.[60] How the plurilateral negotiations will unfold and evolve remains, as of this writing, to be seen. The addition of a non-binding plurilateral negotiating process does not, technically, change the discretion GATS accords to WTO Members to decide how they wish to liberalize their service sectors. The external policy coherency achieved by GATS remains in place, but the attempt by some WTO Members to change the process through which liberalization of trade in services occurs by adding mandatory numerical targets and an obligation to engage in plurilateral negotiations demonstrates that this coherency is vulnerable and must be carefully watched, particularly by those in the health policy community.

3. External Policy Coherency and Intellectual Property Rights. — In the context of external policy coherency, intellectual property rights remain a serious problem. State interests on protecting patents and protecting health have not settled into equilibrium and continue to conflict, causing tension within and beyond the WTO. Evidence of divergence in State interests on patent rights on pharmaceuticals and the TRIPS flexibilities and safeguards can be in found in the controversies leading to the Doha Declaration and the disagreements after the Doha Declaration, including the contentious negotiations on the Decision on the Implementation of Paragraph 6 of the Doha Declaration.[61] More evidence of the lack of external policy coherency on patent rights and health can be located in the controversies generated by the United States' pursuit of "TRIPS-plus" provisions in bilateral and regional trade agreements.[62] These provisions grant holders of intellectual property rights, especially patents, more protection than TRIPS; and critics see the U.S. push for TRIPS-plus provisions as its strategy to circumvent the health-patents balance achieved in multilateral WTO process through and after the Doha Declaration.

The regional and bilateral agreements that contain TRIPS-plus provisions have a potential multilateral impact because of the most-

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[59] *Id.* ¶ 7(b).

[60] World Trade Organization, Ministerial Declaration of 18 December 2005, Annex C, ¶ 7, WT/MIN(05)/DEC (Dec. 22, 2005),.

[61] World Trade Organization, *Decision on Implementation of Paragraph 6 of the Declaration on the TRIPS Agreement and Public Health*, WT/L/540 and Corr.1 (Sept. 1, 2003), at http://www.wto.org/english/tratop_e/trips_e/implem_para6_e.htm.

[62] For a critical analysis of TRIPS-plus provisions, *see* Oxfam, *TRIPS-Plus Provisions*, at http://www.oxfamamerica.org/whatwedo/issues_we_work_on/trade/news_publications/trips/art5391.html.

favored-nation (MFN) principle in TRIPS. Any WTO Member that grants the United States TRIPS-plus protections in a bilateral or regional trade agreement must grant that advantage, favor, and privilege immediately and unconditionally to the nationals of all WTO Members.[63] As the web of agreements containing TRIPS-plus provisions grows, the MFN principle in TRIPS potentially establishes a new *de facto* multilateral level of patent protection not reflected in TRIPS itself. TRIPS-plus politics are, thus, rightly a serious issue to those who are concerned about calibrating trade and health interests with respect to intellectual property rights.

E. Internal Policy Coherency: Synergy in Service of the National Interest

The second level of policy coherence in the context of trade and health is internal. Analysis of external policy coherence proceeded on the basis that States had national interests in trade and health that they managed in their relations with each other largely through multilateral international legal instruments, including the WTO agreements. External policy coherency develops in a symmetrical context: Country G's trade interest bumps up against Country H's health interest, producing a need for equilibrium between the two national interests. Internal policy coherence focuses, instead, on how a country constructs its national interest domestically with respect to trade and health.

The objective of internal policy coherence goes beyond balancing interests in trade and health. The balancing task identified with external policy coherency flows from the interaction of States in a condition of anarchy. Internal policy coherence has the advantage of operating in a hierarchical governance context of domestic politics, which offers prospects for policy coherence to aim for synergy. Domestic actions should be synergistic in the sense of having trade and health interests make different contributions to the same end. Synergistic actions converge in ways that advance the identified end farther than action alone in one area could achieve.

One way to illustrate the synergy at the heart of internal policy coherence is to consider an alternative approach to trade and health issues. Think, for example, of the traditional "wealth produces health" trope. Under this framework, health is not a participant in the construction of the national interest but a by-product of the foreign policy process. Economic considerations alone determine the national interest the State uses in its dealing with other countries through trade. The health benefits created by the economics-only focus are positive externalities the State and its people

[63] TRIPS art. 4.

enjoy when trade produces them. This example describes internal policy monopoly by trade rather than coherency between trade and health.

The balancing of trade and health externally through international legal rules creates the need for those involved in foreign, trade, and health policies within the State to contribute to the formulation of the national interest. The WHO Executive Board considered, for example, the view that WHO Members face "the need to promote a constructive dialogue at national level and to base policies on sound evidence, so that countries could maximize the positive effects of trade and minimize its negative impact."[64] This perspective echoes the relationship of partnership described by Lee and McInnes as "one in which the tools and skills of various policy communities – development, security, public health and foreign policy – are brought together for the greater good."[65] How States integrate trade and health objectives and concerns in constructing their respective national interests is the subject matter of internal policy coherence.

In many ways, internal coherence is a more difficult challenge than external coherence. Even when health ministers and experts have not participated in trade negotiations, international trade agreements produced, by and large, a balance for trade in goods and services that leaves room for States to craft policies and approaches in which the health and trade sectors jointly participate in formulating the national interest. However, such joint participation has not occurred, and still often does not occur, within many countries.

The tendency within States historically has been to marginalize health ministries and experts through a double dose of "stove piping." First, governments often organized their thinking according to the "domestic policy" and the "foreign policy." Health generally fell under the domestic policy category. Second, even within the domestic policy, health often operated in ways disconnected from other policy areas that affected health inputs and outcomes. This double stove-piping meant that health ministries and experts often had more contact with their counterparts in other countries through transgovernmental networks than their own trade and foreign ministries.

Largely through these transgovernmental networks, health ministries and experts began to deliberate on the extent to which the policy space for health within countries was affected by the acceleration of globalization, aided by the evolution of the multilateral trading system in the form of the WTO. Health problems respected no policy stove pipes, but stove pipes

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[64] WHO Executive Board, *International Trade and Health: Draft Resolution – Report by the Secretariat*, ¶ 2, WHO Doc. EB117/10 (Dec. 1, 2005).

[65] Kelley Lee & Colin McInnes, *A Conceptual Framework for Research and Policy*, *in* HEALTH, FOREIGN POLICY & SECURITY: TOWARDS A CONCEPTUAL FRAMEWORK FOR RESEARCH AND POLICY 16 (A. Ingram, ed., 2004).

still structured responses within countries. Integrated threats were met with disaggregated governance. Internal policy coherency on trade and health suffered.

These dynamics demonstrate that internal policy coherence between trade and health in WTO agreements is not organic but has to be deliberately constructed, nurtured, and maintained. Left to their own devices and natural inclinations, trade and health communities would tend to drift back into patterns with which they are more comfortable. These tendencies and historical patterns underscore why internal policy coherency has to be achieved through government and governance architecture and capabilities that maximize the ability of health and trade ministries to contribute to the formulation of a national interest that simultaneously advances health and trade objectives with the framework of the WTO agreements.

F. Towards Trade Epidemiology

Identifying the need for internal policy coherency and describing its general nature are easier, of course, than producing such coherency. The organizational diversity of governments makes concrete descriptions of needed mechanisms and institutions less helpful for the purposes of this article than providing a general approach for achieving internal policy coherency. I call this approach *trade epidemiology*. The basic idea is to mainstream the use of public health principles and techniques, where relevant, in the formulation and implementation of trade policy. The goal is to have health and trade policy converging synergistically in the construction of a more enlightened national interest. Internal policy coherence will not work well if the relationship between trade and health mainly constitutes health officials complaining about trade and the WTO and not offering constructive solutions to make trade and health work together more productively for the good of the country within and outside the WTO.

The trade epidemiology approach might include (but not be limited to) the following kinds of activities:

- *Building the evidence base for policy*: Having more accurate and comprehensive empirical evidence of the ways trade affects public health would enhance efforts to achieve internal policy coherency. The need for better empirical data has been particularly acute with respect to the international trade in health-related services.[66] This effort could involve

[66] Richard Smith, Chantal Blouin & Nick Drager, *Trade in Health Services and the GATS: Introduction and Summary*, *in* INTERNATIONAL TRADE IN HEALTH SERVICES AND THE GATS:

developing a system that organizes and analyzes notifications issued under international agreements related to public health (e.g., SPS Agreement, TBT Agreement) and other forms of information (e.g., ProMed-mail, WHO's Global Outbreak Alert and Response Network) to increase the transparency and quality of data concerning trade and health.[67]

- *Monitoring implementation of existing agreements related to trade and health*: Trade and health ministries should develop harmonized approaches to monitoring how existing agreements that affect trade and health are being implemented by governments and what weaknesses and problems need to be addressed. The WHO Executive Board recommended that the World Health Assembly urge WHO Members "to continue to develop capacity at national level to track and analyse the potential opportunities and challenges of trade and trade agreements for health-sector performance and health outcomes[.]"[68] This task becomes more important and complex as the number of trade agreements a country adopts increases.
- *Integration of public health expertise in negotiations of new agreements and arrangements*: States periodically negotiate new agreements and arrangements that affect trade and health, and health input and/or expertise should be integrated into all diplomatic teams that negotiate these regimes. Accountable and transparent processes should be developed for resolving conflicts between trade and health interests with respect to proposed new agreements or arrangements to ensure that health concerns are not automatically subordinated to trade objectives. These observations recall the WHO Executive Board's recommendation that the World Health Assembly urge WHO Members "to apply, or establish, where necessary, coordination mechanisms involving ministries of finance, health, and trade, and other relevant institutions, to address public health related aspects of international trade[.]"[69]
- *Networking trade epidemiology*: Efforts to improve synergies between trade and health domestically can be aided by

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CURRENT ISSUES AND DEBATES, *supra* note 48, at 13 ("Data on the impact of trade liberalization on health, health services, or the economy are scarce.").

[67] See Ann Marie Kimball, *The Health of Nations: Happy Birthday WTO*, THE LANCET ONLINE, Dec. 15, 2005 (arguing that "[t]here is, at present, no mechanism for systematically referring {WTO] notifications [under the SPS and TBT Agreements] to WHO, the Food and Agriculture Organization, or the Codex Alimentarius").

[68] WHO Executive Board, *supra* note 11, ¶ 1(5).

[69] *Id.* ¶ 1(3).

linking such internal activities with intergovernmental regimes (WTO, WHO) and existing transgovernmental networks. The creation of a working group on trade and health at the WTO might provide a catalyst for broadening and deepening domestic attempts to integrate trade and health policies.[70]

- *Trade for health initiatives*: Trade epidemiology should integrate systematic efforts to stimulate and undertake trade initiatives that could positively benefit health. Such "trade for health" initiatives could include promoting exports of old or new health-related products or technologies; proposals to cut or eliminate tariff rates on important health products and technologies to increase affordable access;[71] supporting international standardization efforts that make products safer and more healthy; providing technical and financial assistance to help developing countries implement health-protecting international standards; awarding prizes to companies that increase access to health-related products and technologies for developing countries; encouraging licensing arrangements to allow foreign manufacture of health-related technologies to better serve poor populations; fostering public-private partnerships that utilize trade to improve health; and creating preferential trading privileges for countries that achieve material progress toward achieving the health-related MDGs.

Trade epidemiology as an approach to internal policy coherency would require institutional change within trade, health, and foreign policy bureaucracies and the development of novel kinds of personnel and information capabilities. Trade epidemiology would depart from what has prevailed in the past, but internal policy coherency's objective of synergy for trade and health cannot be achieved by half-hearted half-measures.

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[70] *See* David P. Fidler, *Draft of a L20 Communiqué on Global Health*, Oct. 31, 2004, at 3, available at http://www.l20.org/publications/Phase%20II/Health/health_fidler_communique.pdf (proposing a Working Group on Trade and Global Health); and Kimball, *supra* note 67(calling for a WTO Committee on Health).

[71] *See* Fidler, *supra* note 70, at 4 (arguing in October 2004 that "[e]fforts to reduce tariffs and other trade barriers that adversely affect access to life-saving and health-promoting products . . . indicate that systematically identifying and reducing such barriers could produce global health benefits."). In February 2006, the United States and Switzerland jointly introduced a proposal at the WTO that would eliminate tariffs on the trade in medicines and medical devices. *See* United States Trade Representative, *United States Seeks to Eliminate Global Tariffs on Medicines and Medical Devices*, Feb. 27, 2006, available at http://www.ustr.gov/Document_Library/Press_Releases/2006/February/United_States_Seeks_to_Eliminate_Global_Tariffs_on_Medicines_Medical_Devices.html.

V. OBSTACLES TO POLICY COHERENCE BETWEEN TRADE AND HEALTH

Achieving policy coherence in the relationship between trade and health in the early 21st century confronts many problems that threaten to drain this project of energy and potential. These threats are, therefore, important to understand with respect to the trade and health relationship for the WTO's next ten years. At the most general level, trade and health coherency may not get high-level political attention and commitment compared to other areas of foreign policy that also demand more coherency in policy making and implementation. The challenge of creating unity of purpose through a diversity of means in the context of networked anarchy forces governments to prioritize their coherency needs in their overall foreign policies.

A. The Policy Triage Problem

Leaving aside the larger foreign policy context, trade and health policy coherency with respect to the WTO may not even rank highly on the agenda of health as foreign policy. Countries face many serious national and global health problems that have urgency not present in the trade and health relationship within the WTO. For example, the perceived threat of pandemic influenza, which is linked to the global spread of avian influenza (H5N1), is increasingly driving the health as foreign policy agenda. This threat highlights the world's lack of public health preparedness and the inadequacies of national and international surveillance and response capabilities for both animal and human health.

The avian influenza crisis certainly affects trade (e.g., imposition of bans on the importation of poultry and poultry products from affected countries), but this communicable disease crisis does not point to obvious external or internal policy coherency problems between trade and health as something requiring urgent attention in the WTO. Similarly, other major global health problems, including the still worsening HIV/AIDS pandemic, the lack of progress on achieving the health-related MDGs, and the need to help developing countries build the core surveillance and response capacities mandated by the IHR 2005, all require actions, such as significantly increased international development assistance, that do not hinge on health's relationship with trade in the WTO.

Given that health ministries in most countries face an increasing parade of public health problems that require, on epidemiological grounds, immediate action, the need for policy triage might marginalize the trade-health coherency agenda or outsourcing it to NGOs. Under-resourced and under-staffed public health authorities may not be able to focus on the trade

and health coherence objective. This problem may be most acute in developing and least-developed countries where such coherency is, in fact, most needed.

The pressures of policy triage may also exist in the realm of trade. Although the Hong Kong ministerial meeting did not collapse in failure, the WTO's Doha Development Agenda remains in trouble. WTO watchers worry about the lack of progress made to date in the Doha Round of multilateral trade negotiations. Incoherency between trade and health stimulated by WTO agreements is not a cause of the Doha Round's travails, nor is it perceived as a major problem presently confronting the WTO's efforts on the Doha Round. Experts are more concerned about the lack of progress in the negotiations on the liberalization of trade in agriculture, the trend of WTO Members adopting regional and bilateral trade agreements, and the lack of progress on, among other things, special and preferential treatment for developing and least-developed countries.

B. Challenges for External Policy Coherence

The lack of urgency concerning trade and health policy coherence in the worlds of foreign policy, health, and trade also connects with issues arising under external policy coherence. As argued earlier, the balance struck between trade and health interests in WTO rules on goods is such that WTO Members have expressed no serious interest in changing them. In terms of services, the addition of plurilateral negotiations for liberalization of trade in services has the potential to stress external policy coherency achieved in GATS. Divergence of trade and health interests is most apparent with respect to patent rights; but, after the Doha Declaration and the agreement on implementation of its paragraph 6, the patent rights controversy has shifted to the context of regional and bilateral trade agreements and TRIPS-plus provisions in such agreements. Given the nature of the divergent State interests on intellectual property rights in the WTO system, the prospects for better external policy coherence on this aspect of the trade-health relationship are not currently promising.

The increasing adoption of regional and bilateral trade agreements complicates external and internal policy coherence in ways beyond the issue of intellectual property rights. The proliferation of these agreements increases the transactions costs for achieving and sustaining external and internal policy coherence. Operating under a single, universally accepted set of rules creates efficiencies for policy efforts geared to monitoring the relationship between trade and health. If trade epidemiology has to manage an increasingly complex set of agreements that does not embody the same rules on goods, services, and intellectual property, then the effort is more time consuming, expensive, and less transparent. Such increased

transaction costs would burden developing and least-developed countries more than developed countries.

The trend toward regional and bilateral trade agreements may also create different substantive balances between trade and health than those struck in WTO agreements. Some regional and bilateral agreements have provisions that are more aggressive on trade in services than GATS and rules that go beyond the intellectual property protections accorded by TRIPS – the "TRIPS-plus" provisions. In such circumstances, external policy coherence, defined as a balance between trade and health interests of States, becomes a series of fragmented and unconnected balances that prevail between different countries.

This situation does not undermine the utility of thinking about external policy coherency, but it complicates assessment of the balance required for external policy coherency to exist. In addition, the more the rules on goods, services, and intellectual property rights differ from the WTO rules, the more likely it is that State interests are diverging in terms of trade interests vis-à-vis health interests. Divergence in State interests on a broader basis may erode the balance represented in WTO agreements that currently produces the external policy coherence that does exist.

C. Challenges for Internal Policy Coherency

In terms of obstacles for internal policy coherence, defined as synergy between trade and health in service of the national interest, many arise from the historical absence of close interagency cooperation between trade and health and the lack of resources health ministries and authorities suffer, particularly in developing and least-developed countries. Given their pressing priorities, trade ministries may not respond with enthusiasm to an agenda that potentially alters how trade policy is made.

With health over-stretched and trade wary, producing synergy between trade and health internally in response to fulfilling obligations under WTO agreements may prove difficult practically and bureaucratically. These dynamics suggest a need for higher-level political intervention before prospects for synergy in the service of the national interest may seem credible. The likelihood of such intervention probably varies from State to State, but this type of intervention may only occur with respect to the most urgent issues or crises and not for the operation of trade epidemiology.

Internal as well as external coherency challenges may also arise from the growing challenges to global health presented by non-communicable diseases. WHO and other public health experts have warned that morbidity and mortality from non-communicable diseases are increasing globally. This increase is epidemiologically related to the consumption of products traded internationally (e.g., tobacco products, processed foods, alcoholic

beverages). Achieving external and internal policy coherency with respect to products associated with non-communicable diseases may be increasingly difficult. The main WTO cases concerning human health adjudicated by the Dispute Settlement Body to date have involved alleged threats of non-communicable diseases.[72] This reality suggests that the relationship between trade and non-communicable diseases raises policy dissonance issues not created by trade-related issues generated by communicable diseases. Controversies about the potential impact of WHO's Framework Convention on Tobacco Control[73] on the obligations of WTO Members serve as further evidence that increasing national and international public health efforts on non-communicable diseases may create friction with internal and external incentives to export products associated with the burden of non-communicable disease. Such friction spells trouble for policy coherence on trade and health at all levels.

VI. CONCLUSION

Whether sustained policy coherence for trade and health in the operation of the WTO agreements can be achieved has become a significant question, particularly for those working on health problems around the world. As this article argued, this question is connected to much larger policy coherency projects that address reinventing foreign policy for the new age of globalized problems. The larger foreign policy perspective allows us to see how health itself has risen as a foreign policy consideration in the last decade, but the rise of health to greater foreign policy prominence does not ensure that achieving policy coherence between trade and health within the WTO becomes a much easier task.

When viewed as a coherency challenge in foreign policy, trade and health policy coherence actually involves two challenges in the form of external and internal policy coherence. The article argued that, of these two, internal policy coherence has proved the most difficult to achieve; and trade epidemiology was offered as a framework for organizing trade and health in such a way that the State's national interest reflects synergy rather than competition between these two areas of political endeavor. The obstacles to external and internal policy coherence for trade and health are, however, formidable, not least because foreign policy, trade, and health all must engage in policy triage that may show that trade and health coherency

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[72] *US – Gasoline*, *supra* note 6 (dispute over clean air standards); *EC – Hormones*, *supra* note 7 (dispute over use of hormones alleged to be carcinogenic: and *EC – Asbestos*, *supra* note 8 (dispute over measures banning products containing asbestos, a known carcinogen).

[73] WHO Framework Convention on Tobacco Control, May 21, 2003, WHO Doc. WHA56.1, Annex, available at http://www.who.int/gb/ebwha/pdf_files/WHA56/ea56r1.pdf.

is not the most pressing concern for States even within the realm of health as foreign policy.

Achieving coherence between trade and health has become increasingly desirable, but responding to this necessity is more complicated and difficult than might at first be imagined. This task requires the State to establish unity of purpose on trade and health and use a diversity of means to steer the national interest through the complex reality of globalization, including the WTO agreements. Replicated across the international system, this approach could produce results that foster human betterment. Sustained achievement of such policy coherency would demonstrate that the anarchical society of States cooperating through the WTO is capable of improving its ability to calibrate the wealth and health of nations.

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