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James Scott and Sophie Harman

Abstract

The current round of World Trade Organization (WTO) negotiations – the Doha Round – has significant implications for global health which have received insufficient attention from the global health community. All too often the health implications of global trade agreements are examined only after their conclusion, and are concerned only with intellectual property rights. This paper seeks to move beyond this narrow focus and elucidate the wider health implications of the Doha Round. It explores the negative effect of the Doha Round on state capacity to provide and regulate health services in low-income countries, and the impact the Round will have on livelihoods among the poor and their ability to access health services. Overall, the paper makes the case for greater engagement from the health community with the WTO and the Doha Round negotiations beyond the customary focus on intellectual property rights.

Beyond TRIPs: Why the WTO's Doha Round is unhealthy

James Scott and Sophie Harman

Since its creation the World Trade Organization (WTO) has been a battleground for global health. The extension of intellectual property protection through the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPs) across the developing world and the restrictions it placed on developing countries in the use of cheap generic HIV/AIDS drugs became an international campaign uniting the global health community and critics of globalisation. This campaign culminated in a reaffirmation of the right of developing countries to use generic drugs when faced with health crises, formalised in the 2001 Declaration on TRIPs and Public Health made at the WTO's Doha Ministerial Meeting concurrently with the launching of the Doha Development Agenda (DDA).¹ The Declaration on TRIPs and Public Health was followed in 2005 by an Amendment to the TRIPs agreement² that allowed developing countries with no domestic pharmaceutical industry to import generic drugs in response to health crises. These two actions – the Declaration and the Amendment – were heralded by some as an example of the WTO adapting to developing country concerns and the potentially progressive agenda of the DDA. The DDA was so-named as it was claimed it would prioritise development alongside special and differential treatment to promote developing country concerns and presence within the WTO. Yet since the battle over TRIPs and generics was concluded there has been little discussion or focus on what the DDA may mean for global health outcomes beyond debates on access to medicine. Particularly absent are questions of what impact the DDA may have on the capacity of the public sector to provide health systems, the ability of the population to access and pay for the use of such systems, and the changing nature of work and lifestyle that the DDA may both directly and indirectly generate.

The purpose of this paper is to begin to think about the gap in our understanding of the DDA and as such to examine several issues within the multilateral trade system and their implications for global health. Following a review of existing analyses of the trade and health interconnection, the paper examines four principal channels by which trade politics and trade agreements impact on health. In section three we highlight some important concerns about the ongoing negotiations in the liberalisation of trade in services – a key demand by the United States (US) and European Union (EU) – and how this may exacerbate health problems. Section four considers the ability of states to pay for healthcare and provide effective health systems and their dependence on foreign aid. The paper explores this with reference to the impact of the DDA on government revenues and aggregate economic wealth in developing countries.

Since public services across many low-income states are of poor quality and accessibility, the ability of individuals to pay for private provision of health services (or indeed to pay the necessary fees and/or bribes

to gain access to the public health system) is critical. Accordingly, the impact of the DDA on livelihoods in poor countries within the context of access to healthcare, changes in employment, diet, and behaviour is examined in section five. Finally, we note that the trade system plays an important role in setting, consolidating and solidifying the rules of the global economic system, with implications for the provision and affordability of health products. The debate over TRIPs and the campaign to reaffirm its provisions for access to cheap drugs illustrate the importance of the multilateral trade system. The impasse within the DDA and the stalling of the multilateral process threatens less powerful countries as their major trading partners move to bilateral and plurilateral agreements containing more restrictive intellectual property provisions than those of the WTO. Bilateral negotiations limit the ability of weaker states to negotiate together in concert with the most powerful developing countries. This is particularly relevant within the context of changing power configurations within the global trade system that have come about with the rise of China, India and Brazil. States such as Brazil and India have been at the forefront of challenges to pharmaceutical patents within the WTO, and the role of these states in DDA negotiations has become prescient to the impact of the trade agenda on potential global health outcomes.

Overall, this paper argues that the DDA as it currently stands holds significant threats to the ability of states to provide health services to their citizens and the ability of individuals to afford health services through the round's negative impact on the livelihoods of the poor. Furthermore, the impasse within the multilateral setting may inadvertently lead to a strengthening of the intellectual property rights (IPR) regimes across the global South through driving a shift towards bilateral trade deals. These issues suggest that the DDA impacts on health beyond the issue of IPR and TRIPs in ways that need to be recognised, highlighted, and addressed.

Beyond TRIPs: where is the global health community?

The global health challenge to IPR, conflicts between campaigns to combat obesity and the food industry, and the contradiction between the General Agreement on Tariffs and Trade (GATT) and aspects of the World Health Organization's (WHO) Framework Convention on Tobacco Control would suggest that health and trade have long been uneasy bedfellows in an interdependent world.³ The GATT and now the WTO continue to be of relevance to public health researchers, advocates and institutions. Such relevance is clear in debate on the correspondence pages of the medical journal *The Lancet*,⁴ internet forums such as the CUTS trade forum, and efforts to reassure the health community of the benefits of a liberalised trade regime by the WTO and efforts to put pressure on the DDA by the WHO.

The clearest area of correspondence lies in the regulation of IPR through trade agreements, most notably the WTO's TRIPs agreement. The attention paid by the global health community to trade matters has concentrated on this area. TRIPs was one of the most controversial aspects of the Uruguay Round, which

created the WTO. Though it contained certain flexibilities for countries to issue compulsory licenses and engage in parallel importing, TRIPs was considered by many to get the balance wrong between the rights of patent holders and the needs of countries to tackle public health crises. This feeling was exacerbated when 39 pharmaceutical companies launched in 1998 (through the US government) a case against the South African Medicines Act, arguing that this Act violated South Africa's obligations under TRIPs. A large-scale campaign by nongovernmental organisations (NGOs) and developing countries eventually led to the US backing-down and allowed South Africa to continue to use generic drugs to combat the HIV/AIDS crisis.⁵ At the launching of the DDA, partly as a response to the need to cajole certain developing countries into supporting the new round, the Members agreed to the Declaration on TRIPs and Public Health which reaffirmed the rights of Members to use flexibilities within the TRIPs agreement in cases of public health crises.

Though hailed as a major victory for social justice and affirming the rights of developing countries against the domination of rich countries, it is important to recognise that the Declaration was merely reaffirming rights that already existed in TRIPs, not creating new rights. The Declaration 'reaffirm[ed] the right of WTO Members to use, to the full, the provisions in the TRIPS Agreement', including 'the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted' and 'the right to determine what constitutes a national emergency or other circumstances of extreme urgency.'⁶ The campaign over TRIPs that culminated in the Declaration was not aimed at bringing about changes in global rules that moved the structures of governance closer to the needs of development. Rather, it was action to prevent a *further strengthening* of the TRIPs agreement at the cost of developing countries' rights and abilities to respond to domestic health challenges.⁷ The US was attempting to extend IPR protection beyond that set out in the TRIPs agreement, and the developing countries, led by South Africa, successfully maintained the status quo.

The Declaration included a provision that instructed the Council for TRIPs to find a solution to a loophole in which 'WTO Members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPs Agreement'.⁸ This was duly done and led to the 2003 waiver that aimed at closing this loophole, subsequently made permanent through the 2005 Amendment of the TRIPs Agreement.⁹ The Amendment will come into effect when two-thirds of the member states formally accept the associated protocol. An initial deadline of 1 December 2007 was set for ratification, subsequently extended three times, most recently to 31 December 2013. At present just 45 Members out of a total of 159 have accepted the protocol.

The waiver is still operational however, allowing eligible Members to make use of flexibilities, if they are able. However, this has been a bone of contention. Much criticism has been levelled at the TRIPs and Public Health Amendment for being too hard for developing countries to make operational, particularly

the poorest among them to which it was aimed. Uptake has been almost non-existent. To take advantage of the provisions, a country must notify the TRIPs Council that it wants to be identified as eligible (though LDCs are exempt from this requirement). So far, no countries whatsoever have done so.¹⁰ A further notification must be made each time generics are imported. So far only one notification has been made in this regard, namely Rwanda importing anti-retrovirals from Canada.¹¹ The Canadian exporting company subsequently criticised the experience for being overly long and complicated.¹² This gives a degree of credence to criticisms that the process of operationalising the rights within the waiver is too onerous.

The high stakes attached to access to cheaper medicines, rules on compulsory licensing (where a government allows a patented product to be produced without the patent owner's consent) and parallel importing (where a product is marketed under patent in one country with the patent holder's permission and then imported into another country without the patent holder's permission);¹³ the role of public health; and how developing countries are able to exert influence in the WTO have formed the focus of the global health community. The WHO has concentrated on health issues relating to TRIPs and the 2001 Declaration on TRIPs and Public Health, and the stumbling block of what constitutes a health emergency.¹⁴ The WHO works both with countries and the WTO in promoting understanding of the health implications of trade, yet systematic studies of the potential impact of the Doha Round on health outcomes have not been forthcoming. Those reviews conducted have been retrospective analyses of the Uruguay Round's General Agreement on Trade in Services (GATS) by key global health researchers such as David Fidler and general reflections on the relationship between the WTO and health that were published at the outset of the DDA negotiations.¹⁵ The World Bank's discussions on the DDA with regard to health similarly focus on TRIPs and how to implement and interpret the agreement and how its limitations can be addressed through advanced market commitments.¹⁶ Indeed, the Bank's 2011 book on the DDA hardly mentions health.¹⁷ An exclusive focus on TRIPs is also found in commentary from the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria.¹⁸ The Bill and Melinda Gates Foundation, which has a rapidly growing role in the financing and policy direction of global health, seems to avoid the topic entirely.

Among more traditional health NGOs the focus on TRIPs to the near exclusion of other areas of interest is equally evident. Publications from advocacy group the People's Health Movement and associated Global Health Watch have continued to provide critically insightful reports and strategies on IPR within the WTO and free trade agreements but have not reflected on the DDA discussions or potential outcomes beyond patent protection.¹⁹ Oxfam International and Health Action International have sustained campaigns on the challenges of patents, patients, and prices²⁰ but again there seems to be little said on the prospects of the final agreement at DDA for health beyond this. Research into the implications of the Doha Round and the international trade regime more broadly have focused on intellectual property and TRIPs,²¹ widening access to trade policy and discussions on patents,²² trade and the right to health,²³ emphasis on the WHO to assert greater agency in trade agreements,²⁴ and the need for the WTO to establish a committee or process that

engages health experts to provide commentary or evidence on health issues affecting trade such as mad cow disease.²⁵ Such research has played a decisive role in challenging the health problems associated with the international trade regime as consolidated by the WTO and the GATT that preceded it. However, there exists a broad silence as to the wider implications of the DDA for health beyond TRIPs.

What we can infer from this silence is that when it comes to health and trade, TRIPs and the blurriness of its 2005 amendment seem to be at the forefront of global campaigns and agendas. This is undoubtedly because the importance of drug prices and availability to some of the poorest communities continues to be one of the biggest threats to people's health. It is crucial that the IPR regime remains at the heart of discussions on health and the DDA since there are clearly significant problems remaining with TRIPs and access to drugs. Yet to focus exclusively on TRIPs without full consideration of the other important impacts of the DDA will undermine efforts to promote health for all. Campaigns on health and trade tend to be retrospective, outlining and critically assessing the impact of previous trade agreements on health without directly engaging with the evolving trade negotiations and potential future impacts. Research and campaigns on preferential, bilateral and regional trade agreements remain the domain of civil society rather than institutions such as the WHO. Past campaigns on TRIPs and HIV/AIDS, and tobacco suggest that global health strategies are effective when institutions capture the influence and pressure of civil society on highlighting concerns. Yet it would seem there is little leadership on taking this agenda forward. The final inference from such silence is that the DDA is implicitly seen as neutral with regard to health outcomes or is a vehicle towards greater improvements in health. However, as we suggest below, there is good reason to suggest that this is not likely to be the case.

Water, sanitation and health services

The creation of the WTO in 1995 incorporated trade in services into the global system of trade governance for the first time, through the GATS. Service provision lies at the heart of many basic health concerns. The core areas of basic health – water, sanitation and health systems, e.g. hospitals, drug supply chains, procurement practices – are all included in the GATS and are therefore also included in the DDA. Services are a very different sector to the GATT's core area of trade in manufactures. The GATS marked the movement of trade governance much further into the area of domestic regulation than before, beyond the previous focus on border measures such as tariffs and quotas. For many core services, liberalisation means little if it is not also accompanied by a process of privatisation as the existence of a public provider effectively prevents the entry of foreign firms.²⁶ Similarly, privatisation is made impossible if not also accompanied by liberalisation of access. As such, privatisation and liberalisation within many service sectors often go hand in hand.

The GATS was not without controversy. After its completion NGOs launched a large campaign against

the opening up of core service sectors (such as water, education and health), and the EU's demands that poor countries open their domestic markets to EU-based water companies. This was intensified after the EU's requests for services liberalisation were leaked to a Canadian NGO,²⁷ which revealed that the EU was requesting the liberalisation of water service sectors across a large number of poor countries. Pressure from NGOs led to the EU reversing its stance and declaring that it would not seek liberalisation of water services within the bilateral request-and-offer process of the GATS negotiations. That, however, left open the possibility of pursuing opening water services within the plurilateral negotiating process – a parallel process occurring alongside the bilateral request-and-offer negotiations.

This episode shows that there has been significant concern with regard to the DDA agenda and its impact on global health. Pollock, Price and Shaoul have argued that the emphasis on privatisation under GATS presents a direct challenge to Europe's welfare and health systems, with evident change being underway in the UK.²⁸ Yet, it is notable that the campaign against the GATS, though involving issues of great importance to health involved almost no health-related NGOs. The campaign was dominated by development and 'anti-corporate' groups.²⁹ After they had successfully pressured the EU to drop demands for liberalisation of water services within bilateral negotiations the movement become inactive, but concerns remain about both water within the plurilateral negotiation process and other areas of GATS related to health. At the most recent (2008) 'signalling conference' in which participating members set out their improved offers in the services negotiations, it was noted that 'Many indications of improvements were given across the range of environmental services, including: sewage services; sanitation services; refuse and solid waste disposal services; [and] waste water management services.'³⁰ This suggests that the process of opening up these areas to foreign companies will be included in any prospective DDA outcome.

Several problems are presented by this. First, developing countries agreed in the Uruguay Round to what they believed was a degree of liberalisation of services but they are now finding themselves pressured to privatise certain areas – something that they had not envisaged. Second, though privatisation and expanding the role of the market in the provision of sanitation and water is not inherently the wrong policy, it does raise concerns for low income countries and for access to core services for the poor. Low income countries tend to lack the capacity for strong regulatory oversight of private actors. In addition, the need to generate profit frequently leads to services being provided in affluent areas only, excluding poor people since they are less able to pay.³¹ State run services often employ a policy of cross-subsidisation in which fees from the rich are partly used to pay for cheaper rates for the poor. This is not readily carried over to the private sector. Many startling success cases of increasing access to clean water and extending sanitation services in developing countries have come from public sector, community-led projects.³² This area clearly deserves greater attention regarding potential impacts on global health.

Effects on state capacity: squeezing state finances

The DDA has other more indirect but no less important implications for health and the capacity of member states to provide health services for citizens. One such issue concerns the impact of liberalisation on government tax revenue. Many developing countries lack the ability to tax their citizens effectively and therefore rely on customs duties for a sizable percentage of their overall government revenue. Figures of 30-40 per cent are not uncommon, rising to as much as 70 per cent for some states such as the Maldives.³³ Cutting tariffs reduces the revenue generated in this way, which is often not replaceable from other sources.³⁴

The loss of tariff revenue is a problem that also accompanied structural adjustment programmes and there is extensive experience of the World Bank and IMF trying to mitigate it through simultaneous tax reform to offset the loss, based on what has been termed a 'tax consensus' between the two organisations.³⁵ This has invariably involved the introduction or expansion of Value Added Tax (VAT), which is favoured for being consumption-based and therefore not distorting economic incentives. Though shifting from tariffs to consumption-based taxes will in neo-classical theory provide welfare improvements if properly designed,³⁶ the structural characteristics of low income developing countries can lead to the opposite result.³⁷ Empirically it has been found that low income countries have managed to recover only around 30 cents in each dollar of lost tariff revenue.³⁸ As such, trade liberalisation in low-income countries leads to falling state revenues, fiscal contraction, and a reduction in the capacity of the state to fund social provision.

Exacerbating this problem is the fact that many developing countries, particularly the poorest, are predicted to be economically worse off by the conclusion of the DDA. Computable general and partial equilibrium modelling has mushroomed in recent years and many studies of the Doha Round have been made using this technique.³⁹ Though the predictions they make vary according to the assumptions made, it is becoming clear that for the poorest countries the gains will be minimal or non-existent. Sandra Polaski, using a model that is more sensitive than most to employment and agricultural livelihoods, estimates sub-Saharan Africa would be made \$106 million worse off by the agricultural deal within the DDA.⁴⁰ Anderson and Martin's authoritative study suggests that low-income countries and sub-Saharan Africa will be left with near zero gain or made poorer by the completion of the DDA.⁴¹ Surveys of CGE studies and political economy analyses finds that not only will the 'measurable' gains be small or negative, the structure of the negotiations are not conducive to the development needs of the poorest countries.⁴²

The impact on health from falling state revenue seems self-evident: with less money in the government pot to spend there will be a decline in the quality and quantity of health provision from the public purse. However, in the immediate term this will not necessarily have a significant impact on the day-to-day health systems of developing countries. Paying for the provision of health systems, public health campaigns,

targeted disease interventions, treatment, procurement and the broad gamut of caring for the health of a population in developing countries comes from a broad mix of public spending, private provision and overseas development aid. What a fiscal squeeze will do is make health systems more reliant on overseas aid. This is problematic in a number of ways. States will continue to depend on aid and the baggage of sovereignty issues, ownership problems, sustainability shortcomings and targets and whimsical strategies that come with it.⁴³ As Haakonsson and Richey note, TRIPs is only part of the problem of access to treatment, with aid and good donor relations also playing an important role.⁴⁴ Targeted development aid has seen some short-term gains in declining HIV prevalence and an increase in uptake and access to anti-retroviral treatment. Development aid has also shown success in developing health systems from procurement procedures to the building of local community health centres. However, without governments being able to match such aid from the public pot most of the decisions of where aid money goes and the types of health systems that are prioritised remain located with that of international donors. Despite showing a sharp increase between 2000-2010, development aid for health interventions has recently been in decline, falling 4.6 per cent in real terms from the previous five year average.⁴⁵ As European and US government spending cuts began to bite, overall ODA fell by six per cent in 2011, and health will take its share of that cut (though data is not yet available). The cost of health provision will as a consequence be met, if at all, by the squeezed poor.

Effect on livelihoods: squeezing the poor

Health provision is everywhere a mix of public and private providers. Across the developing world even where there is formally public provision, actual access to health services usually requires some form of private provision, be it user fees at the point of access, the paying of bribes to underpaid health practitioners, reliance on local healers or community health workers trained in basic palliative care, or, for the fortunate, private insurance schemes issued by their employer. The notion that the state provides access to healthcare facilities that is at a minimum free at the point of access is for many people around the world a false reality and not necessarily an expectation of the state. The lack of state delivery of healthcare suggests that generating revenue through taxation where citizens are unsure of the reciprocal nature of the social contract remains at best a difficulty. As such, in the absence of reliable health services and affordable, prescribed treatment, livelihoods and income distribution are critical factors in assessing how people living in poor countries access healthcare for themselves and their extended families. This section briefly examines the likely effects of the DDA on livelihoods across the developing world.

The model of production that the WTO and the wider project of trade liberalisation promotes is one that favours larger corporations (which are able to take advantage of new trade opportunities) at the expense of small-scale producers (who are generally unable to do so). With 70 per cent of those in extreme (i.e. \$1.25-a-day) poverty found in rural areas,⁴⁶ agricultural productivity, particularly among small-holders, and the

impact of global trade rules on food prices and agricultural employment are critical in assessing the impact of trade agreements on the income of the poor. The impact of trade liberalisation on employment is somewhat understudied. However, a first order estimation can be made that in countries in which production is falling (rising), employment will likewise fall (rise).⁴⁷ The DDA draft text as it currently stands will do little (if anything) to reduce the use of agricultural subsidies by the rich nations. It will merely reduce the level to which they can be raised in the future – a process known as removing the ‘water’ between bound and applied rates. Tariff cuts by developing countries will open their economies to inflows of cheap, subsidised agricultural output from the richer exporting countries, squeezing the incomes of less efficient, small-holder farmers. Where new opportunities are created for expanding exports into rich countries, it is extremely unlikely that such small-holder farmers will be able to respond. Rather, it is large plantations, mostly found in the most efficient producing countries such as Brazil that will benefit.

The problem of opening up the domestic economy to floods of subsidised agricultural products and the resulting threat to domestic farmers has been recognised in the negotiations, and led to the inclusion of provisions for a ‘Special Safeguard Mechanism’ (SSM) that will allow developing countries to raise tariffs to stem import surges,⁴⁸ which are a growing problem,⁴⁹ particularly for LDCs.⁵⁰ In fact, the talks collapsed over the details of the SSM when they came closest to finding an agreement in July 2008. The proposal on the SSM as it currently stands⁵¹ is unlikely to be sufficiently robust to prevent the disruptive effects of import surges.⁵² This is particularly true given that, as previously noted, the DDA is highly unlikely to reduce rich countries’ agricultural subsidies. Hence, the DDA as it currently stands would increase the threat of import surges in agricultural products, whilst failing to tackle a key cause of the problem – food subsidies in rich countries – and providing only weak protection through the SSM.

As such, small-holder farmers are likely to suffer a reduction in their income and security from the DDA. However, it must also be remembered that there is great heterogeneity among those in poverty which makes the impact of trade agreements on the poor difficult to ascertain. For instance, the very poorest, are often unable to produce sufficient food for their needs and are therefore net food consumers, benefiting from cheap food. A rise in agricultural prices creates difficulties for such people to maintain their level of nutrition and hence diminishes their ability to engage in physically demanding agricultural work.⁵³ If they are to be protected from price changes further policy interventions need to be made that protect their access to nutrition.

Changes to livelihoods, how food is produced and the globalised nature of food production and consumption have considerable potential impacts for the health of people living in developing countries with regard to changes in diet and lifestyle and changing behaviour. Dietary transition that was most evident in developed countries during the end of the industrial revolution has been occurring at an accelerated rate in developing countries with the globalisation of food production and marketing over the last thirty years.

On the one hand imports of food produce and new methods of food production and security should provide plurality of choice in low cost produce that has a range of nutritional benefits. However, it can also be the case that the liberalisation of food has introduced and stimulated the consumption of convenience goods that are high in saturated fat, salt and sugar, and low in nutrients. As the WHO puts it, ‘Overall nutrient intake adequacy improves with an increasing variety of foods, but the movement towards more fats, salt, sugars and refined foods quickly moves beyond this more optimal state to one in which diets contribute to rapidly escalating rates of obesity and chronic diseases.’⁵⁴ The introduction of such food stuffs and changes to diet patterns have exacerbated the risk of noncommunicable diseases (NCDs) such as diabetes and heart disease in developing countries. As of 2002, 79 per cent of death from NCDs occurred in developing countries.⁵⁵ The growth of NCDs in these countries has been attributed to industrialisation, urbanisation, and economic development all underpinned by globalisation⁵⁶ that in turn see changes to how people eat food, for example away from home, and the type of food they eat, such as shifting to more processed and cheaper, fatty foods.⁵⁷

NCDs are now a major concern for global health actors, signified by the 2011 high level meeting of the WHO that sought to put such diseases at the centre of the global health agenda. The purpose of the meeting was not only to highlight the prevalence of such diseases around the world but the growing threat they have to the health of populations living in developing countries and the huge strain and burden they will have on underfunded health systems. Changes to the nature of food production in developing countries and the increased importation of food stuffs potentially arising from the DDA will contribute to an acceleration of dietary change towards more saturated fat, high salt and sugary foodstuffs. This will impact on the health of individuals and as such provide greater strain on underfunded health systems as the treatment bill for expensive health problems such as diabetes and cancer increases.

Behaviour change is at the core of most global health strategies and interventions, whether in regard to changes in smoking habits, eating choices or sexual practice. A change in employment is seen to have a clear impact on the behaviour and health choices of individuals. Studies into the rapid acceleration of HIV prevalence in South and East Africa have shown changing patterns of employment and shifts from rural to urban employment and migration to be key factors in changing sexual behaviour and the spread of HIV.⁵⁸ Shifting work patterns in terms of types of employment and sites of employment can generate a number of risk factors for health. The first is the risk to occupational health with a change in skills and new experiences that can affect people’s mental health where they are unable to adapt to change in circumstances and challenges to their employment. The second is that the employment itself could be seen as risky; for example through shifts towards the informal economy – where workers have minimal safeguards, little or no union representation, social insurance or pension. This has specific gendered consequences with women being highly represented in the informal economy.⁵⁹ The third risk factor is that changes to people’s circumstance and living arrangements may alter their approach to risk and perceptions of health. Different contexts and

situations generate different perceptions of risk.⁶⁰ Changes to behaviour arising from the movement of people and shifting contexts can thus have direct consequences on both the spread of infectious and noncommunicable diseases.

It would be somewhat of a leap to put all of these issues of shifting work patterns and behaviour change as solely generated by the WTO – these shifts in employment and changes to work practices have been a feature of the increasingly globalised trade regime that emerged during the industrial revolution and accelerated at the end of the Second World War. However, as it stands the current negotiations further a production system that exacerbates problems of behaviour change, changes in employment, and shifts in diet that will ultimately have an impact on the lives of populations globally. Such changes will most acutely be felt in developing countries that will be stuck in a circular bind of a lack of resources and investment in health systems to combat both current and emerging threats to people's health. Examining the state and the individual levels, the DDA as it currently stands would have a detrimental impact on the capacity of the state to provide health services, and a detrimental impact on the capacity of individuals to afford health care.

The developing country conundrum: the unhealthy Doha Round or regional agreements?

The stalemate within the multilateral trade negotiations is driving countries to turn their attention towards bilateral agreements, both North-South and South-South. Bilateral deals between low-income countries and the likes of India and China are problematic in that they potentially aggravate the process of de-industrialisation taking place within less competitive economies. More importantly for present purposes, are North-South deals. EU and US bilateral agreements tend to include stronger IPR protection – so-called TRIPs-plus provisions – which undermine low-income countries' abilities to provide healthcare in times of crisis. Though, as noted above, TRIPs remains problematic, it does at least include a degree of flexibility and theoretically allows space for the use of generics when necessary. Bilateral TRIPs-plus agreements may omit that space – indeed, existing bilateral deals form one of the reasons for the dismal uptake noted above of flexibilities available in the TRIPs waiver.

The EU's problematic pushing of Economic Partnership Agreements (EPAs) with African, Caribbean and Pacific (ACP) countries, ostensibly to replace the Cotonou Agreement as it was ruled to be incompatible with WTO obligations, is a case in point.⁶¹ EPAs have received huge criticism, described to us by one African WTO delegate as 'The worst thing European countries have done since colonialism.' The EU has insisted on the inclusion of intellectual property rights in EPAs. Unusually, there is no exception to Most Favoured Nation (MFN) status included in the TRIPs agreement for regional trade agreements. This means that any TRIPs-plus provisions that a WTO member country agrees to in a regional trade agreement (such as the EPAs) must be automatically extended to all other WTO members. Thus any extended IPR rules

that the EU manages to extract from ACP countries in the EPA process must automatically be extended by the WTO's MFN principle to the US, for instance, and all other WTO members.⁶² Unsurprisingly, ACP countries have been wary of signing EPAs and so far only one full EPA has been agreed – that between the EU and Cariforum.⁶³ But with the WTO deadlocked and no chance of the DDA being concluded within the next few years due to various countries' election years, pressure will mount to conclude bilateral deals as the major trading nations seek to push forward the liberalisation bandwagon and to carve out areas of influence. If this happens, it could have major implications for the unrolling of unsuitable and damaging IPR regimes across the developing world. Though the changing dynamics of multilateral trade negotiations brought about by the rising powers may have prevented (for now at least) the imposition of an unbalanced, developmentally insensitive agreement in the WTO, it may end up pushing the other developing countries 'out of the frying pan into the fire' through renewing the focus on bilateral deals.

The implications of this problem are that those concerned with health have an interest in ensuring that trade negotiations remain as far as possible at the multilateral level, rather than being shifted to bilateral arenas in which developing countries' political weakness is most exposed. TRIPs remains problematic but bilateral TRIPs-plus provisions are often much worse. If the trade system is not to further harm the access of the poor to life-saving medicines the multilateral forum must be revitalised. The global health community has a role to play in that process.

Conclusion

This paper has argued that the potential impact on the health of people living in some of the poorest parts of the world arising from the DDA is considerable, but has been largely unexplored by the global health community. Too often the linkages between trade and health are reduced only to the effect of IPRs on drug prices, or retrospective analyses of trade agreements. In addition, the DDA is too frequently evaluated in the dry, abstract terms of aggregate dollar-gains derived from computable general and partial equilibrium models, often on the basis of questionable assumptions. Such aggregate pictures have a role to play, but their growing dominance in trade debates is unwarranted and in some regards unhelpful. If we are to understand the impact of the DDA in less reductionist ways we need to move beyond these broad pictures to highlight the impact on the components of human well-being, such as health. The paper highlights the importance of viewing trade agreements through the lens of outcomes for people beyond direct economic gain.

The paper is not a comprehensive assessment of the DDA with regard to health; rather, it is the beginning of such analysis and raises a number of key areas that we consider important. We argue that the DDA as it currently stands has potential implications for the provision of critical health-related services, will reduce the capacity of low-income countries to fund their health systems by squeezing their fiscal resources, and

will have an impact directly, and negatively, on the livelihoods of the poor. Finally, we have highlighted the contentions surrounding the multilateral forum for developing countries, and consequently the importance of engagement by the global health community with the WTO negotiations to help ensure an outcome that furthers, or at worst does not hinder, health targets. The deadlock within the DDA has encouraged a shift to bilateralism, which will include an extension and strengthening of IPR protection across developing countries. This is something of great concern to health providers.

Unless the multi-faceted consequences of the DDA beyond TRIPs are considered the unhealthy DDA will increase the number of unhealthy people in developing countries. This is worthy of greater attention than it has hitherto received and the time for such analysis is now, while the DDA is deadlocked. The current impasse offers a window of opportunity for the implications of the package on the table to be explored and any 'nasty surprises', as the TRIPs agreement turned out to be in the Uruguay Round, highlighted.

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