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**Dying For Trade:
Why Globalization Can Be Bad for Our Health**

by Ronald Labonte, PhD

The CSJ Foundation for Research and Education

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DYING FOR TRADE:

Why Globalization Can Be Bad for Our Health

Introduction

Globalization – the increasing interconnectedness of people and nations through economic integration, communication and cultural diffusion – is not new. Jared Diamond, in his book, *Guns, Germs and Steel* (1997), recounts how the history of most humankind has been one of pushing against borders, expanding, conquering and assimilating. Today’s globalization, many argue, is simply capitalism’s attempt to complete this global colonization process. As before, globalization may bring new benefits to societies. But such expansionary processes also carry many risks, particularly for health. These risks arise through globalization’s largely negative impacts on:

- Poverty and inequality— poverty being the single greatest determinant of disease.
- The environment — the disease perils of over-consumption, pollution and climate change are well known.
- The capacities of national governments – binding trade rules and multi-lateral institutions like the World Trade Organization limit the social and environmental ‘regulatory space’ of national governments, and undercut institutions that support public health and social well-being.

It is globalization’s impact on national authority that cause health activists the greatest concern, since it can prevent governments from enacting policies that lead to health and equity at the local levels where people live, work and play. A concern for many health activists is the impact of the General Agreement on Trade in Services (GATS) on the growing trend towards health care privatization.

This paper examines the impact of trade agreements on our health and health care system, and what governments can do to ensure that health and human development are not sacrificed at the altar of ‘free

trade.' It begins with a discussion of how globalization affects our *global* health through changes in economic growth, poverty, inequality and the sustainability of our environment.

Globalization's harshest impacts have yet to be fully experienced by Canadians. But for the poor living in Africa, the former Soviet republics, and much of Asia and Latin America, the adverse impacts of globalization are lived daily. As Toronto's recent scare with SARS teaches us, our own health is increasingly threatened by 'Diseases without borders'. In this globalized world, we are posed with the challenge of protecting not just the health of all Canadians, but the health of everyone on the planet.

Globalization and Health: The Pros and Cons

First, let's acknowledge that there *are* several potential health benefits of today's globalization. The diffusion of new knowledge and technology, for example, can aid in disease surveillance, treatment and prevention. The globalization of gender rights and empowerment can have tremendously positive health effects. In some poorer countries, when women gain control over household income, they usually invest it in their children's health and education, which benefits the larger community as well as their own family. But these benefits do not stem from free trade policies or from governments attending ever more closely to the needs of big business.

There is also an oft-made economic argument linking globalization with improved health. Liberalization, proponents claim, increases trade. This, in turn, increases economic growth, which increases wealth, which decreases poverty; and any decline in poverty automatically improves peoples' health (Dollar, 2001; Dollar and Kraay, 2000). Improved health, particularly amongst the world's poorer countries, also increases economic growth (Savedoff and Schultz, 2000; CMH, 2001) and so the pro-liberalization, pro-globalization, pro-health circle virtuously closes upon itself.

Sound in theory, this virtuous circle has, in fact, a vicious undertow. This includes the increased adoption of unhealthy 'Western' lifestyles, which underpins our growing global pandemic of obesity

(Lee, 2001). It has also worsened epidemic diseases in developing countries. The World Health Organization estimates that almost 25% of disease and injury worldwide is connected to environmental decline attributable to globalization, with 90% of malaria deaths caused by rainforest colonization and large scale irrigation schemes, which increase exposure to mosquitoes (WHO, 1997a). The diffusion of new health technologies to developing countries, in turn, usually benefits the wealthy, often at the expense of already underfunded and fraying public health care systems for the poor.

As for ‘gender empowerment,’ there is emerging evidence of a global ‘hierarchy of care.’ Women from developing nations employed as domestic workers in wealthy countries send much valued foreign currency back home to their families. Some of this is used to employ poorer rural women in their home countries to look after the children they have left behind. These rural women, in turn, leave their eldest daughter (often still quite young and ill-educated) to work full-time caring for the family they left behind in the village (Hochschild, 2000). Health gains increase for those higher up the hierarchy; health risks accumulate for those lower down.

More fundamentally, trade and financial liberalization does not inevitably lead to increased trade or economic growth. And even when it does, such growth does not inevitably reduce health-damaging poverty, and almost always leads to health-damaging inequality (Cornia, 2001; Weisbrot et al, 2001; UNDP, 2000). Increased trade in goods also means increased use of fossil fuels, more exploitation of already scarce environmental resources, and more toxic pollution. The health damaging effects of all of these are ‘inherently global,’ since contaminants, like diseases, do not respect borders.

Globalization and the Health Scorecard: Unfulfilled Promises and Increasing Threats

Much remains to be understood about how globalization through increased ‘free’ trade might harm or help peoples’ health. But we now have twenty years experience of increased liberalization and

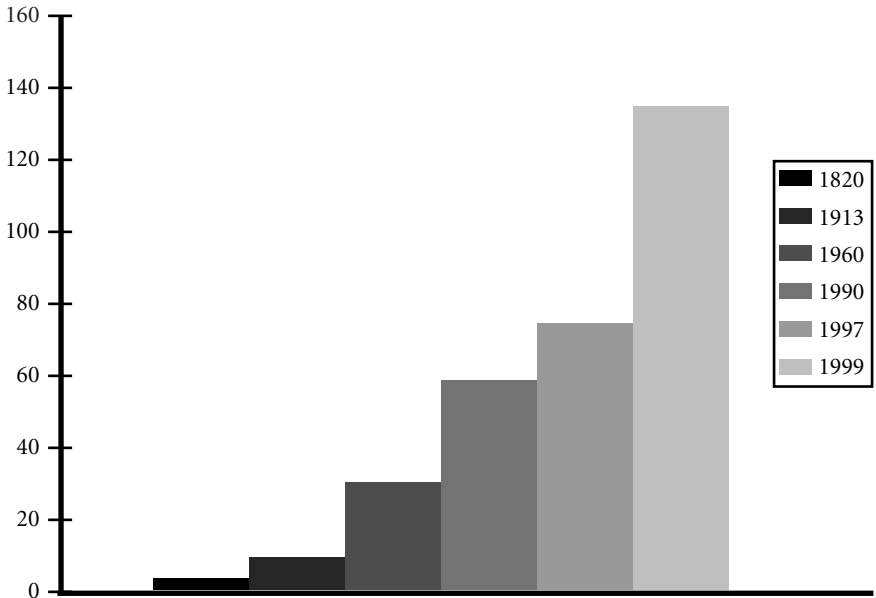
market integration through World Bank and International Monetary Fund (IMF) ‘structural adjustment’ policies of liberalization and privatization imposed upon poorer countries as loan conditions; and ten years experience of enforceable trade rules in which wealthier countries voluntarily agreed to essentially the same policies. With respect to trends in two fundamental health-determining pathways (poverty/inequality, and the environment), the impacts have been largely negative.

Poverty and Income Inequality

The past decade has seen a reduction in global poverty rates at the \$1/day level, but a worsening in such rates at the \$2/day level (Ben-David, Nordstrom and Winters, 1999).¹ We might cynically conclude that our recent era of globalization has successfully transferred income from the extremely poor to the absolutely destitute. Free trade promoters counter that this is simply because poor countries have insufficiently globalized. If they had liberalized more, they would have benefited more. But the empirical evidence doesn’t support this claim, at least for poorer nations. A 1999 study of forty developing and least developed nations found that trade openness (liberalization) actually increased poverty. Those countries liberalizing most rapidly fared worst (Rao, 1999).

This is not true for all countries, however, and there is still much debate whether trade liberalization will eventually succeed in reducing health-damaging poverty. But there is less disagreement that trade liberalization is increasing inequality (see Figure 1). Whether income inequality is the root of disease remains a contentious topic amongst population health researchers (Deaton, 2001). Yet, as much recent evidence makes clear, across the world inequalities *are* associated with declines in social cohesion, social solidarity and support for strong states with strong redistributive income, health and education policies that have been shown to buffer liberalization’s un-equalizing effects (Deaton, 2001; Global Social Policy Forum, 2001; Gough, 2001). The developing countries experiencing the greatest economic growth (China, Vietnam and India) are also the ones experiencing the sharpest increases in income inequality.²

**FIGURE 1: Rising Global Inequalities:
Income Ratio of World's Wealthiest to Poorest 20% of the World's
Population, 1820 - 1999.**



1820-1999. (Source: UNDP, 1999)

A recent 'scorecard' provides more evidence that globalization has been far from equal in distributing its benefits. This scorecard compares health, economic and development indicators for the 'pre-globalization' (1960-1980) and 'rapidly globalizing' (1980-2000) periods (Weisbrot et al, 2001). During the globalizing period, economic growth per capita declined in all countries, but declined most rapidly for the poorest 20% of nations. The rate of improvement in life expectancy declined for all but the wealthiest 20% of nations, indicating increasing global disparity. Infant and child mortality improvements slowed, particularly for the poorest 40% of nations. The rate of growth of public spending on education also slowed for all countries, and the rate of growth for school enrolment, literacy rates and other educational attainment measures slowed for most of the poorest 40% of nations.

A study by Branko Milanovic, a World Bank economist (2003), reached a similar conclusion: In the pre-globalization period, two out of four of the world's poorer regions grew faster than the wealthier nations of Western Europe, North America and Oceania (Australia and New Zealand). During the globalization era of the last twenty years, this was reversed with growth in rich countries outpacing that of any other region. The greatest beneficiaries from the policies of today's globalization have been the wealthy nations largely responsible for creating its rules.

The Environment and Sustainable Development

There are two primary pathways linking globalization to the environment: (1) the liberalization-induced effects of growth on resource depletion and pollution, and (2) increased transportation-based fossil-fuel emissions. Ecological limits to growth and consumption are rarely considered in economic growth models, yet if all countries 'developed' to the same consumption patterns found in Canada and the US, our species would require four more planets to exploit ((Footprints of the Planet Report, n.d.). There are also numerous examples where trade and investment liberalization have increased the pace of environmental damage.

The combined effects of deregulation, privatization, and weak governmental controls on the Indonesian logging industry, implemented to increase economic growth through increased trade, have led to the loss of more than one million hectares of forest per year. Health effects range from short-term and widespread respiratory disorders associated with extensive burning to long term ecosystem disturbances and potential climatic change (Walt, 2000). In Uganda, trade liberalization in the form of industrial privatization and tariff reduction on fishing technology contributed to over-fishing of the Nile perch in Lake Victoria, and a degradation of the lake's ecosystem and water quality (UNEP, 2001), with potentially severe health impacts – about 20% of all deaths in children under 5 in developing countries are caused by unsafe or insufficient water (WHO, 1997b).

Mauritania, a poor sub-Saharan African country, has sold fishing rights to factory-ships from Europe, Japan and China to earn the foreign currency it needs to pay back liberalization-induced foreign loans. Meanwhile, fish, the staple protein for the country's poor, has largely disappeared from local markets (Brown, 2002). Child malnutrition and health, previously improving, is now worsening (Social Watch, 2002, 2003). In Argentina, trade liberalization and promotion of fisheries exports led to a five-fold growth in fish catches in the decade 1985-95. Fishing companies gained an estimated US \$1.6 billion from this growth. But depletion of fish stocks and environmental degradation has produced a net cost of US \$500 million (UNEP, 2001). Loss of fish stocks increases food insecurity, and public investments to rebuild stocks come at the cost of funding essential health care or educational services.

There are also indirect climate change effects due to de-regulation of foreign investment. A recent example of this was the Brazilian currency crisis of 1998, precipitated by the greatest inflow and outflow of speculative capital ever experienced by a developing country (UNDP, 1999; de Paula and Alves Jr., 2000). The government lacked sufficient foreign reserves to stabilize its currency and was forced to borrow from the IMF. The rescue package called for drastic public spending cuts, including a two-thirds reduction in Brazil's environmental protection spending. This led to the collapse of a multi-nation funded project that would have begun satellite mapping of the Amazonian rainforest as a first step in stemming its destruction. The loss of this program combined with ongoing logging will have a profound impact on climate change, with long-term and potentially severe health implications for much of the world's populations (Labonte, 1999). Hopefully the Brazilian government's more recent commitment to set aside large tracts of the remaining Amazonian rainforest will begin to change this bleak assessment (Mitchell, 2002).

Most empirically-based projections of the environmental impacts of trade liberalization show severe ecological damage (Labonte and Torgerson, 2002). Especially damaging are agricultural and fisheries subsidies, which go primarily to wealthier producers within wealthy

countries, and wreak havoc on local production in poorer countries by flooding the market with below-cost commodities that severely damage the environment. WTO members in 2001 committed themselves to “reductions, with a view to phasing out, all forms of [agricultural] export subsidies; and substantial reductions in trade-distorting domestic support” (WTO, 2001a). But the EU and Japan, which heavily subsidize their domestic farmers, have been slow to comply; and the US Bush Administration in 2002, despite the 2001 agreement, signed into law the largest increase in domestic farm subsidies in American history.³ There will be no winners from such policies, and the biggest loser will continue to be the environment.

Health Care, Privatization, and Trade Agreements

Of course, our health is determined by much more than our environmental and economic conditions. Above all, our health care systems determine the care we receive when sick. The concern for many of us with globalization is how trade agreements affect the increasing privatization of our public health care system. The problem with increased privatization, alongside a ‘public’ system, is that it leads to inequalities in access. As private health care expands for those who can afford it, the higher salaries and better working conditions it offers pulls health care professionals away from the public system, leading to the public system’s slow decline or collapse.

In Brazil, for example, private health care currently provides 120,000 physicians and 370,000 hospital beds to the richest 25% of the population, while the public system has just 70,000 physicians and 565,000 hospital beds for the remaining 75% (Zarrilli, 2002a). Another effect of increased health care privatization is a decline in support for universal public programs by higher-income earners in favour of ‘user pay’ private insurance and private health care systems.

Trade agreements are *not* the cause of today’s health care privatization. But trade agreements ‘lock in’ current levels of privatization and can prevent any future expansion (or re-creation) of the public system. There are three trade agreements with a direct bearing on

Canada's public health care: NAFTA (North American Free Trade Agreement), GATS (General Agreement on Trade in Services) and TRIPS (Agreement on Trade Related Intellectual Property Rights).

NAFTA

NAFTA's negative impacts on public health care arise from its Chapter 11 provisions that permit private *foreign* companies to sue democratically elected governments if their regulations result in 'expropriation' of real or potential earnings. Canada, for example, withdrew its intent to legislate 'plain packaging' for cigarettes when American tobacco companies threatened to sue our government for 'expropriation' of their intellectual property, i.e., their trademarks. NAFTA does allow governments to expropriate foreign-owned investments, but only if it is for a public purpose.

The problem for Canada is that because the provinces have allowed health care privatization to increase in recent years, it is hard to argue that our health care system is administered strictly for a *public* purpose. This opens the door to NAFTA claims that measures to expand public health insurance in Canada to prescription drugs, home care and dental care, or to restrict private for-profit provision of health care services, amount to expropriation and that compensation must be paid to American or Mexican investors who are adversely affected. Article 15 of the Free Trade Area of the Americas' (FTAA) Chapter on Investment similarly allows investor-state suits. It is currently "bracketed" text, meaning there is as yet no agreement amongst the nations negotiating the FTAA on its content. Canadian FTAA negotiators, however, are not calling for its removal.

GATS

The General Agreement on Trade in Services (GATS) is a WTO agreement. There is considerable pressure from commercial services groups, particularly in the US and European Union (EU), to use GATS to open up government services for commercial and foreign provision (Sinclair, 2000). European negotiators are urging greater service liberalization because they see China as a lucrative market, as

that country dismantles its previous state welfare infrastructure (Pollock and Price, 2000). Private US health care providers regard GATS as the main vehicle for overcoming market access in countries where public funding and provision currently predominate.

Health services liberalization, proponents claim, can lead to new private resources to support the public system, introduce new techniques to health professionals in developing countries, provide such professionals with advanced training and credentials, and introduce new and more efficient management techniques (Zarrilli 2002b). But there are powerful counter-arguments to each of these points. Private resources disproportionately benefit the wealthy and increase the regressive privatization of health systems. Private investments in health services concentrate in services for the affluent that can afford to pay for them (Lethbridge, 2002), undermining support for universal, public provision of health services. Liberalization in the movement of health professionals can worsen the already critical ‘brain drain’ from under-serviced poor countries to wealthier nations (see Box 1). Finally, there is nothing preventing countries from trading in health services in any of these modes *without* making any commitments under the GATS agreement. The only effect of such commitments is to make it extremely difficult for countries to change their minds in the future.

To date, 54 WTO members have made commitments to liberalize some health services under GATS (Adlung and Carzaniga, 2002). (See Table 1) The number of health-liberalized countries grows to 78 if one includes private health insurance. The GATS agreement has a built-in requirement for “progressive liberalization” meaning that countries can only liberalize more, not less. Once a service sector has been committed under GATS, there is no cost-free way of reversing it (Canadian Centre for Policy Alternatives, 2002). Canada committed private health insurance under GATS in 1994. Should Canada wish to extend its public system into areas that are privately insured, and so reverse the current trend away from privatization, this commitment could trigger trade penalties.

Box 1: The “Brain Drain”

Each year the global “brain drain” of trained health professionals from developing to developed countries gets worse. Developing countries are estimated to lose over US\$500 million each year in training costs alone of doctors and nurses who migrate to wealthier nations (Frommel, 2002). The problem is most acute for African countries, but also exists for many Caribbean countries. Several Canadian provinces, such as Alberta and Saskatchewan, have actively recruited health professionals from South Africa to fill their own vacancies in rural communities (Bundred & Levitt, 2000). The South African government in 2001 formally complained to the Canadian government over the number of its physicians being allowed to take up practice in Canada, yet in 2002 the number of South African-trained physicians in Canada increased by another 174, to total 1,738 (McClelland, 2002).

The problem is not simply active recruitment by wealthier countries – a result of their own poor health human resource planning – or even the “pull factors” of higher earnings and greater opportunities available in other countries. There are also the “push factors” of low salaries, lack of positions and little infrastructure for research or advanced training, problems that are rooted in the under-development of public health systems in poorer countries.

The GATS agreement offers an exception for “a [government] service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers” (Article 1:3b). This is often cited as evidence that concern over privatization is misplaced. This clause, however, may collapse under an eventual challenge, since most countries allow some commercial or competitive provision of virtually all public services (Sinclair, 2000; Pollock and Price, 2000).

Table 1: Commitments to Liberalize Health Services

<i>Service Category</i>	<i>Total WTO Members</i>	<i>WTO Developing Country Members</i>
Medical and dental services	54	36
Hospital services	44	29
Nursing and midwifery services	29	12
'Other' health services	17	15

(Source: Adlung & Carzaniga, 2001, 2002).

Health care is not like other commercial services. It is essential to the creation and maintenance of a public good. Public systems for health care arose in most countries because private systems proved inadequate and inequitable. Whatever problems exist with health care provision today, increased privatization and private sector involvement is not the solution. Whatever forms of cross-border exchanges in health services we might want to engage in, for all of the positive reasons cited in favour of GATS, let us be clear on this: Trade treaties – which are intended to promote private commercial interests – are no place to negotiate international rules for health, health care and other essential public goods such as education and water/sanitation.⁴

TRIPS (Agreement on Trade-Related Intellectual Property Rights)

Unlike other WTO agreements, TRIPS does not 'free' trade, but 'protects' intellectual property rights, almost all of which are held by companies or individuals in rich countries. The TRIPS agreement requires WTO members to legislate patent protection for twenty years, although least developed countries don't have to do this until 2016. One effect of the TRIPS agreement has been to increase sharply drug costs in most countries, including Canada. This decreases the amount of public funding available for primary health care or other public programs in first world countries, where 75% of prescription drug costs are publicly or privately insured. But it is particularly hard on persons living in poor countries where the health portion spent on drugs is already much higher and often a direct personal cost.

The TRIPS agreement does allow countries, in cases of public health emergencies, to issue compulsory licenses to generic drug manufacturers. The Doha Declaration on the TRIPS Agreement and Public Health (WTO, 2001b) strongly affirmed these provisions. But the Doha Declaration failed to solve the problem of developing countries that have to ‘parallel import’ these drugs from other countries such as Brazil or India, something the TRIPS agreement currently does *not* allow.

Last December, the US scuttled a complicated WTO deal that some thought already watered down the Doha declaration (WTO, 2002). After insisting on even more measures to prevent cheap generics from entering rich country markets, and pleas from African countries reeling from AIDS, a new compromise deal was struck. But groups like Doctors Without Borders claim the new restrictions will still price generics out of the reach of poor countries. The deal is a far cry from the promise made in Doha, and many developing countries view it only as stopgap.

WTO Agreements and Health Determinants

The risks that trade agreements pose to public health care systems are real and need urgent attention. But health care is only one determinant of our health. Other important determinants include income, education, safe water and sanitation, healthy lifestyles, employment, workplace and environmental health, and supportive social relationships (what is sometimes today called “social capital” or “social inclusion”). Each of these determinants is affected by domestic public policies that, in turn, are increasingly affected by trade agreements.

Some of these health-damaging effects are general in nature. Trade liberalization lowers tariffs (taxes) on imported goods. This reduces the amount of revenue that governments have to spend on health, education, and environmental protection. Tariff reduction hasn’t meant much for wealthy countries, such as Canada, which collect less than 4% of their public revenue from tariffs (World Bank, 2000). But it has been hard on developing countries, which get

much of their revenue from tariffs. Between 1980 and 1997, for example, tariffs as a percentage of total national taxes fell from 48% to 23% in Jordan, 50% to 16% in Sri Lanka, and 39% to 12% in Botswana. In the past decade, the Congo Republic saw its international tariff share of tax drop from 21% to 6%, and Mauritius from 46% to 26% (World Bank, 2002). Few countries experiencing these declines have been able to institute alternative revenue-generating sources, and have not experienced sufficient growth in trade to offset the drop (Hilary, 2001). This seriously reduces these countries' abilities to provide public health, education and water/sanitation services essential to health.

Trade liberalization can also damage the more fragile domestic economies of developing countries. In return for World Bank and IMF loans, Zambia opened its borders to cheap, often second-hand textile imports. Its domestic manufacturing, inefficient by wealthier industrialized nation standards, could not compete. Within eight years, 30,000 jobs disappeared and 132 of 140 textile mills closed operations, which the World Bank acknowledges as "unintended and regrettable consequences" of the adjustment process (Jeter, 2002). Huge numbers of previously employed workers rely on precarious street vending. User charges for schools have led to increased dropout and illiteracy rates. The Zambian government is now seeking to undo most of these policies. But this is proving difficult because of the extensive economic and social damage now existing.

Finally, liberalization of financial markets (investment) has led to 'tax competition' which, by one estimate, costs developing countries over US\$50 billion in foregone corporate taxes each year (OXFAM, 2000). This is more than the estimated additional annual costs of ensuring adequate health care for every woman, man and child on the planet.

Several WTO agreements *specifically* restrict the right of governments to regulate for health and environmental protection. The *WTO Agreement on Sanitary and Phytosanitary Measures* requires that a country's food and drug safety regulations be based on a scientific risk assessment, even if there is no discrimination between

domestic and imported products (Drache et al, 2002). Canada joined the US and Brazil in a WTO dispute to force the EU to accept imports of hormone-treated beef. The EU does not allow the use of these hormones on its cattle. There is also evidence that these hormones may cause cancer in animals. But the WTO dispute panel (which did not include any scientists) concluded that the EU failed to conduct a proper scientific risk assessment proving that hormones were a human health risk.⁵

The *Technical Barriers to Trade Agreement* requires that all domestic regulations be “least trade restrictive,” and treat “like products” the same. Domestic regulations can be higher than international standards only if they can be justified. Canada used this agreement to argue that France’s ban on the use of asbestos products was discriminatory since asbestos was “like” the glass fibre insulation France allowed. Canada lost this case – the only such instance where the WTO ruled in favour of health over trade – partly because of the enormous amount of scientific data proving the cancer-causing risks of asbestos (WTO, 2000)⁶. This certainty of proof is rarely the case with most human or health hazards.

The *Agreement on Trade-Related Investment Measures* prevents countries from placing performance requirements (such as requiring local content) on foreign investment. Such requirements have been used to benefit corrupt government officials or their families. But they have also proven useful in the development of a viable domestic economy, partly by ensuring health-promoting employment and income adequacy for marginalized groups or regions. Similarly the *Agreement on Government Procurement* requires governments to take into account only “commercial considerations” when making purchasing decisions, banning preferences based on environment, human or labour rights. Currently a voluntary agreement to which few developing countries have signed on, wealthy countries, including Canada, are pushing to make this agreement mandatory and binding on all WTO members.

What Can Be Done?

Governments have had a hand in creating today's globalization by negotiating multi-lateral trade agreements. They can also play a major role in changing these agreements, and in shifting the trajectory of globalization away from purely economic objectives that benefit elites, towards health and human development goals that benefit everyone, especially the poor. If they are seriously committed to social justice, governments - including our own - must make the following policy changes.

Protect Our Health Through Promoting Public Services

There should be a full “carve out” from trade agreements of public services essential to our health (health care, education, water/sanitation, occupational and environment health). To its international credit, Canadian trade negotiators have listened to this repeated argument from health and social policy activists, and have put their trading partners on notice that Canada will *not* commit any of our health, education or social services under GATS, nor ask that any other WTO member do so. But our private health insurance commitments remain a weak link and, more importantly, GATS negotiations are ongoing with the intent to progressively liberalize more services. Many observers believe that pressures to liberalize health and other essential public services will continue to build unless stronger and internationally agreed upon exceptions for such services are created. There are at least two ways this can be done:

1. Negotiate a general exception in the GATS agreement freeing any services related to health care, water/sanitation or education from the requirement for progressive liberalization; or a full “carve out” of these services from any of the GATS “disciplines” (trade penalties). A country could then withdraw GATS commitments in these services at any time without invoking a trade penalty.

2. Create international agreements on exchanges, including trade and investment, in these services, *outside* of the WTO structure and under the goal of achieving improved and greater equity in health outcomes. The Canadian government is working on a similar agreement to protect cultural diversity rights. Are essential health-promoting public services any less important?

Discriminate in Favour of Developing Countries

Countries need strong domestic economies to create the income and employment necessary to fund the public services essential to health. As the Zambia story showed, today's weaker economies cannot become strong if they are forced to compete with goods and services from already well developed economies. The WTO in its founding documents recognized the need of developing countries for "special and differential" (S&D) exceptions to trade rules that might otherwise damage their domestic economy or for which they lacked the domestic capacity to comply. A 'level playing field' (one set of rules for everyone) only becomes fair when all of the players can equally play the game. WTO members at the Doha meetings affirmed the need for different rules for poorer nations when they declared that the WTO should review "all Special and Differential provisions...with a view to *strengthening them...*" (WTO 2001a; emphasis added). But negotiations at the WTO to do just this have failed to produce any tangible results because many of the wealthier WTO member-nations, including Canada, object to this necessary double standard.

Wealthier member-nations of the WTO need to accept developing countries' requests for stronger S&D exceptions *even if these may have negative economic impacts for wealthier member-nations in the short term*. Developing countries should be able to use such exceptions for purposes of health and human development (in particular, to fulfill their obligations under the 'right to health'), and for domestic economic development. Their right to do so should be a core, non-negotiable principle of the WTO, and should be based not on a given time period (as is the present case), but on when they

attain a certain level of economic development (as has been urged by many UN agencies, developing countries, international development organizations and the European Union).

Reverse the Burden of Proof

The burden of proof in health and environmental protection disputes argued under the exceptions in GATT XX(b) and the Sanitary and Phytosanitary Agreement should be reversed. Countries claiming that another nation's domestic standards are unnecessarily trade restrictive need to prove that they were *not* imposed for health reasons, and that changing the standard would *not* create a health risk.

Fines, Not Sanctions

The WTO has the option to levy fines instead of trade sanctions, but rarely does. Fines, especially if tied to a country's Gross Domestic Product, would create a much fairer penalty system. Part of the fines could even go to global funds for health, education and social development, allowing the dozens of countries now lagging behind in reaching the Millennium Development Goals for infant and child health, maternal health, gender empowerment and universal education to start catching up.⁷

Human Rights Oversight

Finally, existing agreements must continually be assessed for their impacts on internationally-agreed human rights, human development, health and environmental sustainability goals, with changes made when WTO agreements conflict in any way with their accomplishment. The WTO as an institution should be judged for how it contributes to accomplishing these goals, rather than on the degree to which it succeeds in trade and investment liberalization.

Conclusion

The above suggestions focus on reforms at the WTO, an organization that is only nominally democratic (one country, one vote). The economic clout of wealthier nations, and the larger and much better funded teams of negotiators they have at the WTO, means that most of our global trade rules so far have disproportionately benefited rich countries, often at the expense of poor ones.⁸ There are signs this is changing, as developing countries increasingly organize around *their* interests, often supported by evidence from independent UN agencies, researchers and development agencies, and by activism from civil society groups around the world. This hasn't yet resulted in fairer trade rules, but it has ground WTO negotiations to a near-halt.

Some activists urge the complete elimination of the WTO, and the two other institutions – the World Bank and IMF – that are most responsible for today's global economic rules. Others call for their reform, particularly for the WTO. At this juncture, reform may be the best option, as simply eliminating the WTO will mean the return to bilateral trade agreements (those between two countries) and, as experience has shown, these invariably benefit the more powerful nation. Currently, the US, in its trade negotiations with individual developing nations, demands that they give up some of their rights under WTO agreements, including their right to avoid patent legislation under existing TRIPS provisions. The WTO at least allows developing countries to unite against the self-interests of wealthier countries.

For the moment, WTO reform is a necessary but insufficient global reform. Whether the United Nations and its various agencies can regroup after the assault on its credibility by the US/UK invasion of Iraq is a hotly debated question. But we desperately need effective multilateral institutions that are democratic, transparent, equitable and guided by goals of health and human development, including commitments to the global redistribution of wealth and power.

We live in perhaps the most important historical moment of our species. Our planet is dying amidst excessive affluence and poverty. Once far-away conflicts and diseases imperil global health and security. Thirty years ago social justice activists around the world rallied to the idea of a 'global village'. But what dominates today is a 'global market'. The challenge we face is how to re-regulate economic practices that governments have allowed to slip beyond their own domestic control. We know the global policy options that will work to promote health. Just as we know that the new rules must be shaped to the differing needs of rich and poor countries, and subordinated to health, human rights and environmental objectives. The problem we must solve is how to create a system of global governance for our common good. Our health depends on it.

EndNotes

¹ The \$1 and \$2 a day figures refer to the average income earned by individuals in poorer countries. The calculations are made by the World Bank, and have been criticized for faulty assumptions that substantially underestimate global poverty rates. Nonetheless, they are still useful benchmarks for comparison over time.

² Economic growth is important to improving peoples' health but, in itself, is insufficient. First, there is little gain in average life expectancy once per capita income approaches US \$5,000 (Wilkinson, 1986; World Bank, 1993). Second, much depends on how the wealth of economic growth is shared or invested. There are high growth/low health countries (Brazil) and low growth/high health countries (Sri Lanka, the Indian State of Kerala, Cuba). Many of the low growth/high health countries have policies supporting social transfers to meet basic needs, universal education, equitable access to public health and primary health care, and adequate caloric intake (Werner and Sanders, 1997) – pro-poor policies that are now being eroded by trade liberalization.

³ The US Trade Representative, Robert Zoellick, subsequently proposed global reductions in such subsidies, including those in the US (*BRIDGES Weekly Trade News Digest* 6(38) 7 November 2002). This is a common ploy by wealthier countries in the WTO. Before agreeing to reduce trade-distorting tariffs or subsidies in sectors important to their own economies, they first dramatically raise them.

⁴ Some trade agreements may even violate the 'right to health' guaranteed under the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights, to which Canada is a 'State party.' In 2002 the UN Commission on Human Rights created the position of a Special Rapporteur to recommend measures to promote and protect this right. In his first report (Hunt, 2003) the Rapporteur noted that "States are obliged...to ensure that no international agreement or policy adversely impacts upon the right to health, and that their representatives in international organizations take due account of the right to health" (28), specifically citing the GATS and TRIPS Agreements as potentially violating this right. Over 100 countries recognize a right to health in some form in their constitution, and all but a few countries have ratified human rights conventions that include the right to health (Blouin, Foster and Labonte, 2002). The exact standing of the right to health in Canada is not as clear as it is for countries where this right has been written into their constitutions.

⁵ The EU still does not allow hormone-treated beef into its countries, and is paying millions of dollars each year to the complaining countries in compensating trade sanctions.

⁶ Article XX(b) of GATT (the WTO's General Agreement on Tariffs and Trade) permits exceptions to WTO rules "necessary to protect human, animal or plant life or health."

⁷ A related idea, though outside the WTO ambit, is to create a 'Tobin Tax' on currency exchange. Such a tax, named after the Nobel economist who first proposed the idea, would impose a small tax each time foreign currencies were exchanged. This will dampen tremendously damaging speculation and, based on 1995 data, would raise about US \$150 billion annually. Such a tax could be split three ways, with a third going to each national government whose currencies were being traded, and the remainder to an international development fund.

⁸ A recent and important book, based on interviews with WTO staff and delegates, shows the many ways in which an ostensibly democratic system is subverted to ensure that the 'agreements' that are reached are those the major powers – primarily the US and the European Union – want, irrespective of the views or interests of most developing countries, who form the great majority of the membership (Jawara and Kwa, 2003). The problems it identifies suggest precisely how the WTO might be reformed to be more democratic in fact, and not just in principle.

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