LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

Global trade and health

Richard Smith

Professor of Health System Economics

Dean of Faculty of Public Health and Policy

THE LANCET

Trade and Health · January, 2009 www.thelancet.com

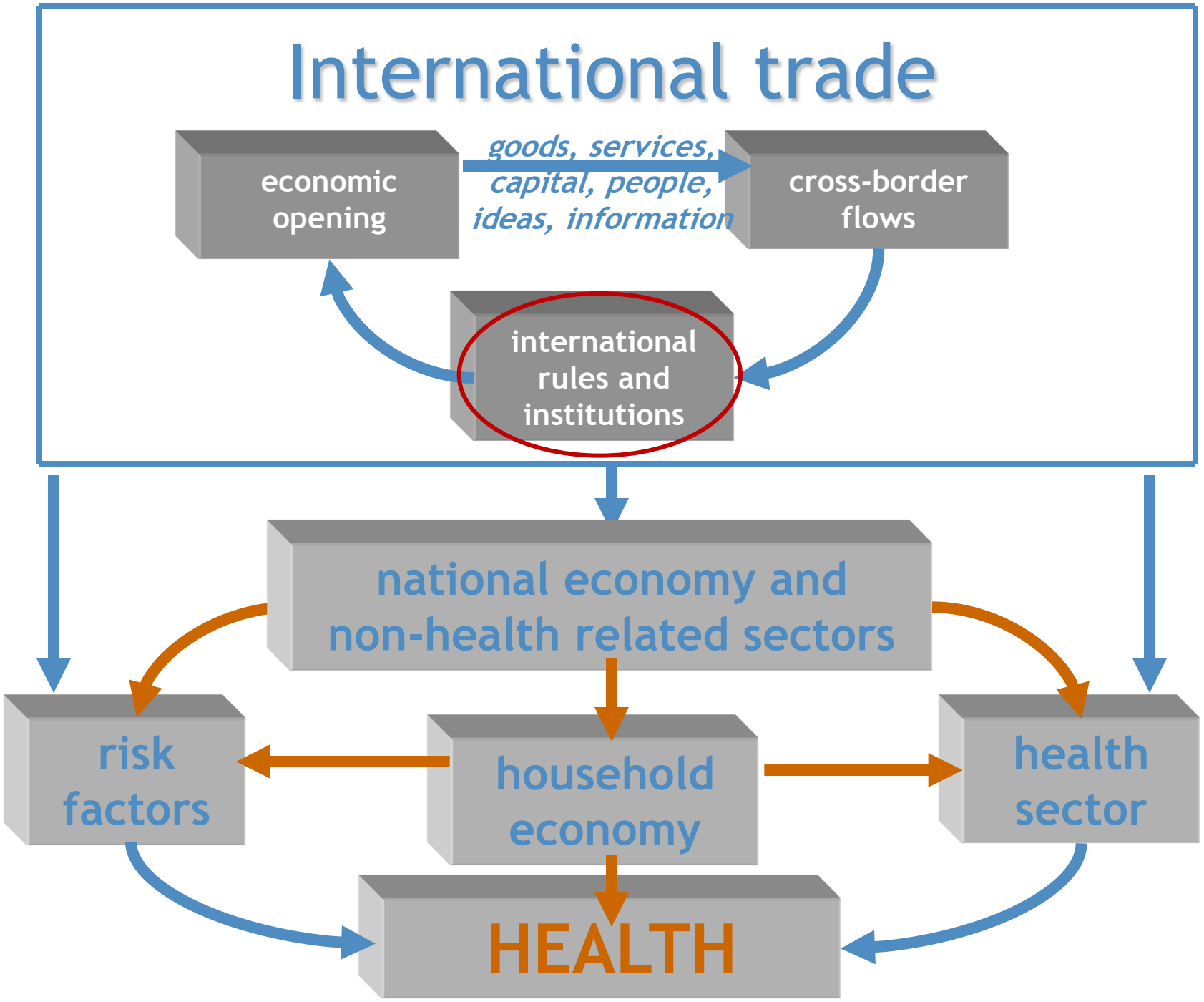
"The fact that trade directly and indirectly affects the health of the global population with an unrivalled reach and depth undoubtedly makes it a key health issue that the global health community can no longer ignore."

Trade: what and why?

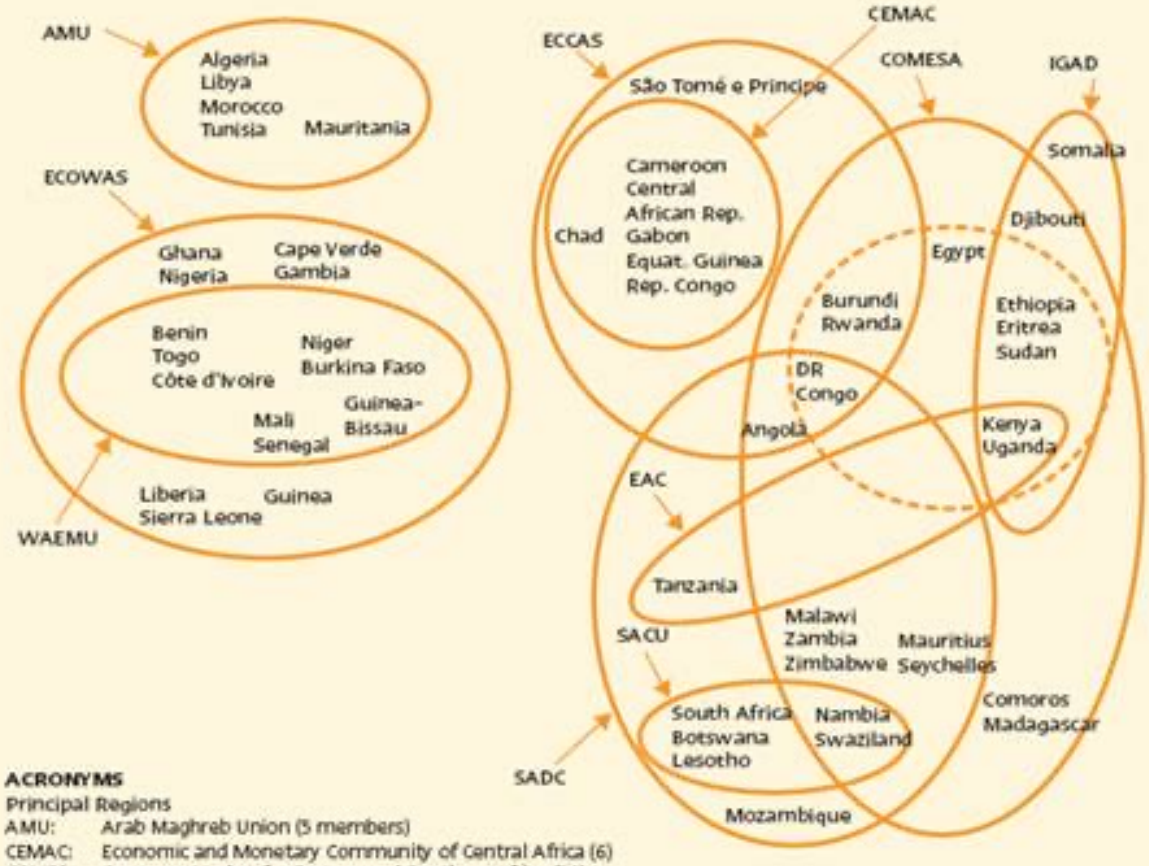
- International trade
  - Trade refers to the exchange of goods and services, and underpins all markets. International trade is exchange between countries
- Law of comparative advantage
  - Countries specialise in production, and trade for goods from others who are similarly (relatively) more efficient at producing those other goods
  - Trade increases global production, which increases product variety and reduces unit costs, leading to increased GDP, wider selection of goods, higher employment, higher tax revenues, etc.

Trade expansion

- Late 19th century levels of cross border trade in relation to GDP comparable to today
- Early 20th century characterized by protectionist policies led to decline in trade (political unrest)
- Late 20th century increase liberalization policies
  - 1945-1970 trade increased 14 fold
  - 1970-97 percentage of countries with free-market liberal economies rose from 8% to 28%
- Increase in bilateral and regional trade agreements to liberalize trade (reduce barriers)
  - NAFTA, ASEAN, EU, etc


International trade
economic opening
goods, services, capital, people, ideas, information
cross-border flows
international rules and institutions
national economy and non-health related sectors
risk factors
household economy
health sector
HEALTH

Africa trade agreements



ACRONYMS

Principal Regions

AMU:	Arab Maghreb Union (5 members)
CEMAC:	Economic and Monetary Community of Central Africa (6)
COMESA:	Common Market for Eastern and Southern Africa (20)
ECCAS:	Economic Community of Central African States (11)
ECOWAS:	Economic Community of Western African States (16)
SADC:	Southern African Development Community (14)
WAEMU:	West African Economic and Monetary Union (8)

Geographically limited or subsets of larger groups

EAC:	East African Community
IGAD:	Inter-Governmental Authority for Development
SACU:	Southern African Customs Union

Figure excludes CEN-SAD, CEPGEL, IOC and MRU

TPP: trade-offs for health behind closed doors

A dozen countries have signed the Trans-Pacific Partnership, a major trade agreement that has complex implications for global health. Ted Alcorn reports from New York.

On Feb 4, 2016, after 7 years of negotiations, representatives from the USA, Japan, and ten other countries signed one of the largest trade and investment agreements in years, the Trans-Pacific Partnership (TPP). The negotiations were closed to the public, who only glimpsed drafts of the agreement when they were occasionally leaked. The participants were heavily lobbied by major industries. And the final language has complex implications for domestic policies in the participant countries, including for public health. As legislators consider ratifying the agreement, close observers question how future negotiations could be made to yield a more representative, more legitimate outcome.

Striking a balance on drugs

In the popular imagination, trade agreements reduce tariffs and eliminate

so by demanding higher prices from consumers, and when those consumers are poor and in acute need of medicine, this can stop ill people from receiving life-saving care.

The TPP requires signatory countries to lengthen this period of monopoly by a variety of means. Manufacturers of new biological drugs—the large and growing group of medicines manufactured in or extracted from biological sources rather than synthesised chemically—will have between 5 and 8 years before their

> "The TPP...includes measures that allow drug makers to extend their monopolies, for example by withholding regulatory approval for competitive drugs until the producers have demonstrated they do not violate active patents."

a compromise. They were an improvement, she said, but the original position of the USA was so extreme that the final terms remained "completely disproportionate". Apart from the duration of exclusivity, she objected to the concept of exclusivity itself: "They are perpetuating an innovation system that is not working." In its place, MSF has called for an entirely new system for financing and incentivising innovation that doesn't require patients and treatment providers to pay higher prices for new drugs.

Generic drug manufacturers were more circumspect. Nawel Rojkjaer, senior director of international affairs at the world's second largest generic drug manufacturer Mylan, said their company weighs the entire global market in its decisions to develop new "biosimilar" copies of biological drugs. So lack of access to any individual

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The vulnerability of being ill informed: the Trans-Pacific Partnership Agreement and Global Public Health

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Will the next generation of preferential trade and investment agreements undermine prevention of noncommunicable diseases? A prospective policy analysis of the Trans Pacific Partnership Agreement

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Emerging threats to public health from regional trade agreements

Deborah Gleeson, Sharon Friel

The decision by Australia's High Court to uphold the constitutionality of the country's ground-breaking tobacco plain packaging laws[1] has been heralded as a victory for national sovereignty over vested interests.[2] However, the ability of governments worldwide to introduce and implement public health policies and laws is increasingly threatened by trade and investment treaties that privilege investors over governments and provide avenues for international corporations to challenge democratically enacted public health policies in different countries.[3,4]

The risks are clearly shown by Philip Morris Asia's challenge to Australia's plain packaging laws under the investor–state dispute settlement (ISDS) provisions set out in an investment treaty between Australia and Hong Kong.[3] The action by Philip Morris Asia seems to be part of a global strategy by the tobacco industry to use international trade and investment dispute mechanisms to undermine tobacco control measures. Other such disputes include investor-state actions by tobacco companies against Uruguay and Norway and challenges within the dispute mechanisms of the World Trade Organisation (WTO) brought against both the USA and Australia by other countries.[5,6]

Through the ISDS mechanism, Philip Morris Asia is seeking the suspension of enforcement of Australia's plain packaging legislation, or millions of dollars in compensation on the grounds that the value of its investment has been affected by the supposed expropriation of its trademarks and related branding.[7] Australia, however, has a strong case, in part because Philip Morris Asia acquired its holdings in Philip Morris Australia in February, 2011, after the Australian Government had announced its intention to introduce plain packaging.[8]

value of US$20734 billion in 2011),[10] in a region that represents 40% of global trade.[11] More countries are likely to accede in future: Japan, Thailand, and the Philippines have already expressed interest in potentially joining. Arguably a geopolitical manoeuvre on the part of the USA—which is seeking to stake its claim in the region as a counter to China—the TPP might tilt the axis of economic power towards this region of the world, and, by setting an ambitious precedent, reset global trade rules.

Negotiations for the TPP began in March, 2010, and the 16th negotiating round will begin on March 4, 2013, in Singapore. Negotiations are held under conditions of confidentiality and draft texts are not publicly available. The agreement includes 29 chapters or negotiating areas,[12] ranging from traditional trade issues such as trade in goods and technical barriers to trade, to areas in which unprecedented commitments have been proposed, such as regulatory coherence as well as stronger intellectual property rights and investor protections than those provided by previous trade agreements.

Regional trade agreements such as the TPP are emerging in the context of countries being unable to gain the terms they want through the multilateral trading system generally overseen by the WTO. During the past decade, the WTO has been progressively abandoned by wealthy countries in favour of bilateral and regional trade agreements, leading to multiple overlapping trade commitments of increasing complexity.[13]

The capacity for regional agreements such as the TPP to create and exacerbate health inequities derives, in part, from their inherent power imbalances. Wealthy countries have more bargaining power to negotiate advantageous trade rules, and tend to use this power to gain concessions that they are unable to obtain through

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LONDON SCHOOL of HYGIENE & TROPICAL MEDICINE

EDITORIAL

Brexit's Great Repeal Bill will axe the right to health

Essential protections will be lost if government plans go ahead

The fundamental right to health in the UK will be lost if the government proceeds with its plan not to convert the EU Charter of Fundamental Rights[1] into UK law, as announced in the white paper on the Great Repeal Bill.[2]

The value of this charter was shown last year, in both EU[3] and UK[4] courts, when the tobacco industry unsuccessfully challenged the new rules on plain packaging of cigarettes.[5,6] One of the industry's

and air and water quality. The change will considerably weaken the ability of judges in future to uphold the law if it is challenged by industry in the courts.

The government puts forward two arguments to support its intention to dispense with the charter. The first is that because the charter applies only when the UK is acting within the scope of EU law "its relevance is removed by [Brexit]." This is a technical point that ignores the serious implications of the change.

The value of the EU charter was shown last year, when the tobacco industry unsuccessfully challenged the new rules on plain packaging of cigarettes

the ECHR, including, for example, the right to an effective remedy and fair trial, and to same sex marriage.

World Trade Organization

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WTO and health

HEALTH ISSUES	WTO RULES			
	SPS	TBT	TRIPS	GATS
• Infectious disease control	*	*		
• Food safety	*			
• Tobacco control		*	*	*
• Environment	*	*		
• Access to drugs			*	
• Health services				*
• Food security	*			
Emerging issues				
• Biotechnology	*	*	*	
• Information Technology			*	
• Traditional knowledge			*	

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Public Health

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Implications of the World Trade Organization in combating non-communicable diseases

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SUMMARY

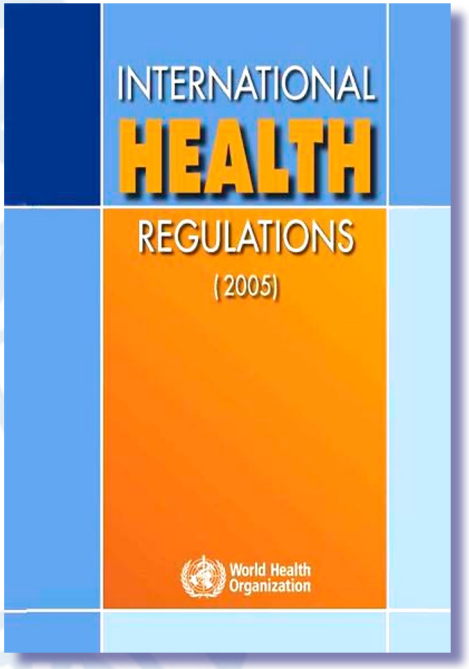
The World Health Organization (WHO) has proposed a number of strategies to combat non-communicable diseases such as cancers, cardiovascular diseases, chronic respiratory diseases and diabetes by targeting the risk factors of tobacco use, harmful use of alcohol and poor diet. A number of the domestic regulatory responses contemplated by WHO and individual countries have the potential to restrict or distort trade, raising the question of whether they are consistent with the obligations imposed on Members of the World Trade Organization (WTO). This article demonstrates that WTO rules do limit Members' flexibility in implementing public health measures to address these diseases. However, the focus of WTO provisions on preventing discrimination against or between imports and the exceptions incorporated in various WTO agreements leave sufficient scope for Members to design carefully directed measures to achieve genuine public health goals while minimizing negative effects on international trade.

Governance clash

- centralised structure
- extensive and expanding membership
- comprehensive scope
- detailed, complex and legally binding agreements
- dispute settlement mechanisms

- fragmented, unstructured, lack of lead institution
- WHO influence from technical expertise and nonbinding recommendations
- lack of broad, deep or binding legal commitments
- lack of dispute or enforcement mechanisms

International Health Regulations



"In the globalized world, diseases can spread far and wide via international travel and trade. A health crisis in one country can impact livelihoods and economies in many parts of the world. ... The IHR aim to limit interference with international traffic and trade while ensuring public health through the prevention of disease spread."

http://www.who.int/features/qa/39/en/index.html

International Health Regulations

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EBOLA AGAIN SHOWS THE INTERNATIONAL HEALTH REGULATIONS ARE BROKEN: WHAT CAN BE DONE DIFFERENTLY TO PREPARE FOR THE NEXT EPIDEMIC?*

Trygve Ottersen,† Steven J. Hoffman†† & Gaëlle Groux†††

Whither WHO....

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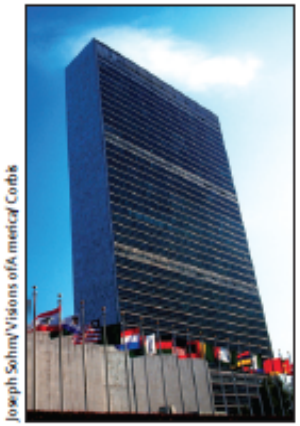
What can the UN General Assembly do for global health?



Joseph Sohm/Visions of America/Corbis

See Comment pages 1001, 1002, 1005, and 1006

See Articles page 1029

See Review page 1049

5 years ago the most important international event in global health was still the World Health Assembly, held in Geneva each May. At that gathering, Ministers of Health meet and decide global priorities and strategies for improving the health and wellbeing of their peoples. WHO visibly expresses and demonstrates its leadership at the Assembly, with technical staff guiding ministers in their decision-making and planning. The Assembly is the platform from which global health's supreme inter-governmental authority—WHO's Director-General—speaks to the world about its collective successes, challenges, and opportunities. But that week in May has now been eclipsed by a gathering with even greater political weight: the UN General Assembly (UNGA), held in New York next week.

Why has New York superseded Geneva? The UNGA is where Heads of State, not merely Ministers of Health, gather. It is sadly true that most health ministers lack domestic political muscle. They might talk tough among themselves, but back home they have to get in line behind colleagues in finance, defence, trade, and even education. In New York, if a Head of State chooses to lead his or her delegation on a health topic, others stop, listen, and pay attention. In New York next week, Prime Minister Shinzo Abe of Japan will lead on Universal Health Coverage. Prime Minister Stephen Harper of Canada and President Jakaya Kikwete of Tanzania will lead on women's and children's health. They will get the kind of attention and audience their health ministers can only dream about.

New York also matters because this is where an increasing number of critical reports are published and debated among policy makers, agencies, and politicians. For example, UNICEF uses the UNGA to publish and disseminate its latest numbers for child mortality, thereby drawing maximum high-level political attention to child survival. Indeed, it is at the UNGA where the future of the post-2015 agenda will be forged. The General Assembly is now an event that cannot be ignored by the health community. Keep an eye on New York next week. Interesting things are likely to happen. ■ *The Lancet*

Global Health Diplomacy

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

- Brings together the disciplines of pubic health, international affairs, political science, law, economics to focus on ***negotiations that shape and manage the global policy environment for health***

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journal homepage: www.elsevier.com/locate/socscimed

Review article

Global health diplomacy: A critical review of the literature

Arne Ruckert [a, *], Ronald Labonté [a], Raphael Lencucha [b], Vivien Runnels [a], Michelle Gagnon [c]

Smith and Irwin *Globalization and Health* (2016) 12:28
DOI 10.1186/s12992-016-0169-5

Globalization and Health

COMMENTARY Open Access

Measuring success in global health diplomacy: lessons from marketing food to children in India

Richard Smith[1*] and Rachel Irwin[2]

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Global health in foreign policy—and foreign policy in health? Evidence from the BRICS

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EDITORIALS

Rethinking governance for trade and health

The mechanism for dispute settlement in preferential trade agreements risks riding roughshod over health

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Walls et al. Globalization and Health (2015) 11:14
DOI 10.1186/s12992-015-0099-7

GLOBALIZATION AND HEALTH

COMMENTARY Open Access

Improving regulatory capacity to manage risks associated with trade agreements

Helen L Walls[1,2,3*], Richard D Smith[1,2] and Peter Drahos[3,4]

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Capacity building for global health diplomacy: Thailand's experience of trade and health

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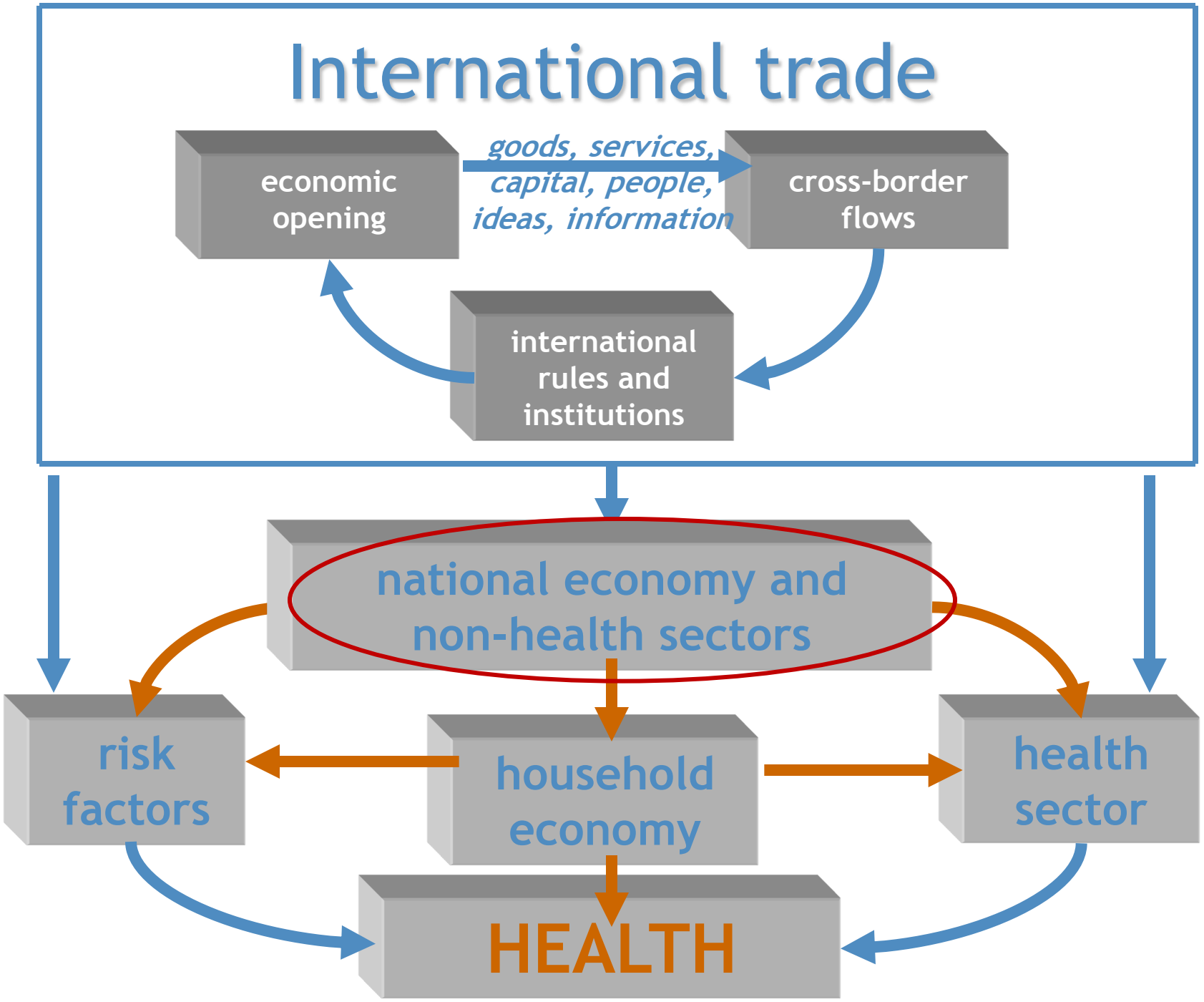
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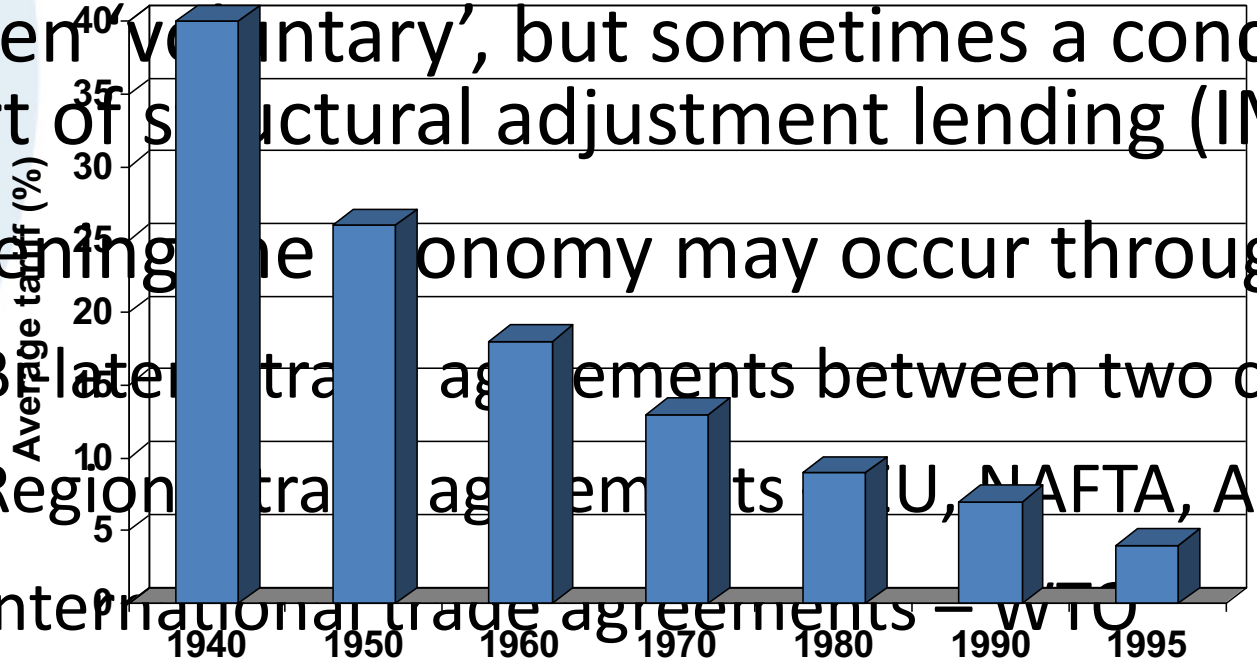
cross-border flows
international rules and institutions
national economy and non-health sectors
risk factors
household economy
health sector
HEALTH

National economy and trade liberalization

- Most countries increasing openness of economy to trade (reducing tariffs, quotas etc)
  - Average tariffs on goods fallen over last 20 years Brazil 34-12%, China 43-9%, India 83-28%
- Often 'voluntary', but sometimes a conditional part of structural adjustment lending (IMF, WB)
- Opening the economy may occur through:
  - Bilateral trade agreements between two countries
  - Regional trade agreements – EU, NAFTA, ASEAN
  - International trade agreements – WTO



Trade liberalization and health

- Increasing trade liberalization impacts *health*
  - changes in income influence nutrition, education, housing, water & sanitation, etc
  - import tax policies concerning tobacco, alcohol, firearms will influence supply & demand for them
- ...and health *care*
  - exchange rate impacts cost imported vaccines etc
  - government income (available for HCE) often relies on import tariffs – liberalisation reduces tariffs and government revenues (MICs recover 60%, LICs 30%)

Health outcomes during the 2008 financial crisis in Europe: systematic literature review

Divya Parmar,[1] Charitini Stavropoulou,[1] John P A Ioannidis[2]

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Impact of 2008 global economic crisis on suicide: time trend study in 54 countries

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By David Dranove, Craig Garthwaite, and Christopher Ody

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HEALTH AFFAIRS 34,
NO. 8 (2015): 1368–1375

The Economic Downturn And Its Lingering Effects Reduced Medicare Spending Growth By $4 Billion In 2009–12

OPEN ACCESS Freely available online

PLoS one

The Impact of Economic Crises on Communicable Disease Transmission and Control: A Systematic Review of the Evidence

Marc Suhrcke[1], David Stuckler[2], Jonathan E. Suk[3], Monica Desai[4], Michaela Senek[1], Martin McKee[4], Svetla Tsolova[3], Sanjay Basu[5], Ibrahim Abubakar[1], Paul Hunter[1], Boika Rechel[1], Jan C. Semenza[3]*

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HEALTH ECONOMICS LETTER

HOW MANY INFANTS LIKELY DIED IN AFRICA AS A RESULT OF THE 2008–2009 GLOBAL FINANCIAL CRISIS?

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ABSTRACT

The human consequences of the recent global financial crisis for the developing world are presumed to be severe, but few studies have quantified them. This letter estimates the human cost of the 2008–2009 global financial crisis in one critical dimension—infant mortality—for countries in sub-Saharan Africa. The analysis pools birth-level data, as reported in female adult retrospective birth histories from all Demographic and Health Surveys collected in sub-Saharan Africa. This results in a data set of 639,000 births to 264,000 women in 30 countries. We use regression models with flexible controls for temporal trends to assess an infant's likelihood of death as a function of fluctuations in national income. We then calculate the expected number of excess deaths by combining these estimates with growth shortfalls as a result of the crisis. The results suggest 28,000–50,000 excess infant deaths in sub-Saharan Africa in the crisis-affected year of 2009. Notably, most of these additional deaths were concentrated among girls. Policies that protect the income of poor households and that maintain critical health services during times of economic contraction may reduce the expected increase in mortality. Interventions targeted at female infants and young girls can be particularly beneficial.

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KEY WORDS: financial crisis; infant mortality; sub-Saharan Africa

Health Economics, Policy and Law, page 1 of 6
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Editorial

The global financial crisis, health and health care

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SARAH GREGORY
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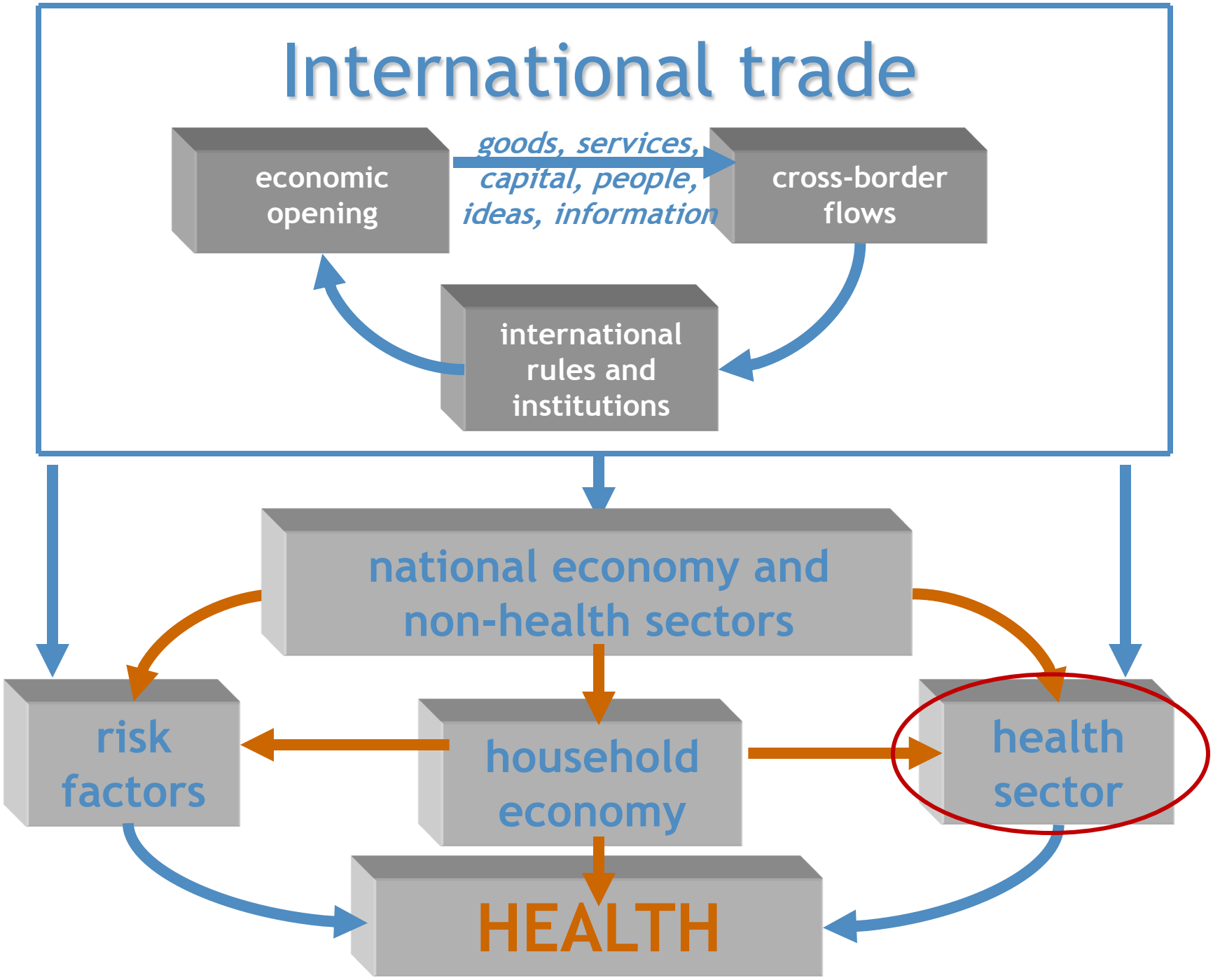
From the early outward signs of a collapse in the US sub-prime mortgage market in the spring of 2007, the global banking crisis unfolded. Financial institutions thought too big to fail, failed. In the summer of 2007 the French bank BNP Paribas ceased activity in three hedge funds that specialized in US mortgage debt. Meanwhile, in Britain, on 14th September investors in the bank, Northern Rock, withdrew over £1 billion in the biggest run on a bank in the United Kingdom for more than a


International trade
economic opening
goods, services, capital, people, ideas, information
cross-border flows
international rules and institutions
national economy and non-health sectors
risk factors
household economy
health sector
HEALTH

Trade and health *care*

- Trade in health *care* has traditionally been focused on goods – pharmaceuticals & medical devices – which can be stored and transported.

Pharmaceutical trade

- Pharmaceuticals are the most important health-related product traded (55% of all health-related trade, US$650 billion market)
- Highly concentrated in a few private companies in developed countries (and increasingly so)
- Generates a clear divide between rich and poor countries:
  - generates trade deficit in modern medicines
  - reduces affordability and access, and 'skews' R&D
- Reinforced through TRIPS (and 'TRIPS-plus')

TRIPS agreement

- TRIPS (1995) established global minimum standards for IP protection, incl. patents
- Provisions for protection within TRIPS but few countries have taken up
  - various exemptions from patentability, limited exceptions to patent owners' exclusive rights, compulsory licensing and parallel importation
- Rather, they have generated circumvention of TRIPS with more stringent standards ('TRIPS+')
  - Bilateral trade agreements where IP protection standards in excess of TRIPS exchanged for trade concessions (eg access to agricultural markets)

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How the Trans Pacific Partnership Agreement could undermine PHARMAC and threaten access to affordable medicines and health equity in New Zealand☆,☆☆

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ABSTRACT

New Zealand's Pharmaceutical Management Agency (PHARMAC) has been highly successful in facilitating affordable access to medicines through a combination of aggressive price negotiations, innovative procurement mechanisms, and careful evaluation of value for money. Recently the US government, through the establishment of a series of bilateral and plurilateral "free" trade agreements, has attempted to constrain the pharmaceutical access programs of other countries in order to promote the interests of the pharmaceutical industry. The Trans Pacific Partnership Agreement (TPPA) represents the latest example; through the TPPA the US is seeking to eliminate therapeutic reference pricing, introduce appeals processes for pharmaceutical companies to challenge formulary listing and pricing decisions, and introduce onerous disclosure and "transparency" provisions that facilitate industry involvement in decision-making around coverage and pricing of medicines (and medical devices). This paper argues that the US agenda, if successfully prosecuted, would be likely to increase costs and reduce access to affordable medicines for New Zealanders. This would

India–EU free-trade pact could stifle generics industry

Health activists are concerned that a free-trade pact being negotiated between India and the European Union could hamper the production of generic drugs. Patralekha Chatterjee reports.

India and the European Union (EU) are in the midst of negotiating a Bilateral Trade and Investment Agreement—a market-opening pact that could vastly expand trade between the two in goods, services, and investments. The ambitious deal-in-the-making, however, has come under intense scrutiny for its potentially adverse effect on the health of millions in India and across the developing world.

Whatever the final shape the proposed free-trade agreement (FTA) between India and the EU takes, the ongoing closed-door negotiations have fired up the debate about trade, medical innovation, and public health. Since negotiations kicked off in 2007, protest marches, press conferences, and social media activism have whipped up pressure within and outside India, galvanising the public health community into flagging their two most pressing concerns—access to affordable drugs and access to information.

policy makers and industrialists believe that India, an emerging economic power, needs to strengthen its IPR regime to bond better with the world's largest economy, the EU. Public health advocates, humanitarian aid organisations, civil society groups, as well as Anand Grover, the UN Special

> "'Trade negotiations and the way lobbyists try to influence them should be fully transparent. We consider this a prerequisite for...good trade deals that benefit society...'"

Rapporteur on the Right to Health, strongly disagree. They say that data exclusivity might delay or even prevent the registration of, and price competition through, generic drugs. Overall, according to the activists, a tighter IPR regime could bind India to stronger protections than the World Trade Organization's trade-related aspects of intellectual property rights

association of leading Indian drug companies.

On the eve of further high-level talks in Brussels on the EU-India FTA, Minister Sharma reaffirmed to *The Lancet*, "There is no question that we will accept data exclusivity in any [free trade] agreement with any country. On [the] intellectual property rights issue, whatever is discussed has to be in compliance with the TRIPS commitment."

Such statements have lifted the spirits of the activist community and India's generic drug industry but, with the trust deficit between FTA negotiators and the other side, the response is one of cautious optimism. Médecins Sans Frontières (MSF), which heavily depends on Indian generic drugs for its programmes and has 175 000 HIV-positive people on treatment, has welcomed Minister Sharma's statement, but Leena Menghaney, a campaigner with MSF India, pointed out that the EU is

Industry lobbying and trade pacts threaten India's role as major supplier of generic drugs

Nav Care Home in Delhi was able to look after 45 HIV positive orphans because of access to cheap drugs

SUSHIL KUMAR VERMA/REUTERS

Ganapati Mudur NEW DELHI

Indian manufacturers have supplied more than 80% of antiretrovirals to developing countries since 2006, a new study has shown, amid concern that trade negotiations and industry lobbying threaten to restrict this flow of affordable generic drugs.

The study also shows that Indian generic drugs accounted for 91% of all antiretrovirals for children supplied to developing countries in 2008 (*Journal of the International AIDS Society* 2010;13:35). Of 100 countries surveyed, 96 relied on Indian generic drugs; and 99% of antiretrovirals used by DR Congo, Mozambique, and Namibia came from India.

Indian generic formulations accounted for 65% of the $463m (£295m; €353m) purchases of antiretrovirals in 2008, while non-Indian generics made up 13% and brand name drugs made up 22%, the study found.

Suerie Moon, from the Harvard Kennedy School of Government in Cambridge, Massachusetts, and one of the study's authors, said, "Indian generic antiretrovirals have cost consistently and significantly less than other generics."

The most common first line regimen of generic antiretrovirals from India for adults cost $74 per person per year in 2008, while brand name regimens reported to the agency Médecins Sans Frontières cost up to eight times this amount.

However, the study warns that the free trade agreements that India is currently negotiating with the European Union may create new obligations that will increase the prices of antiretrovirals and delay access to new and improved versions of generic formulations.

The closed door negotiations have sparked concerns about India accepting fresh restrictions that may block progress in generics. "When India introduced product patents on medicines in 2005, the space for generic production was seriously curtailed. Any further restrictions would add insult to injury," Ms Moon said.

Leaked documents released by non-government health organisations in India last week suggest that multinational drug companies have contacted the top echelons of the Indian government bureaucracy in their attempts to seek fresh changes in intellectual property rules. The documents show that senior officials from five companies met bureaucrats in the office of the Indian prime minister earlier this year to make a presentation on intellectual property enforcement and data protection.

The prime minister's office had subsequently forwarded notes from the Organisation of Pharmaceutical Producers of India, a group seen as representing foreign drug companies, with suggestions relating to intellectual property rights to the Indian health ministry seeking its comments.

Anand Grover, director of Mumbai's Lawyers Collective, who has campaigned for the rights of people with HIV for two decades, said, "This suggests that sections of the multinational pharmaceutical industry are trying to change Indian laws in an insidious, non-transparent manner."

Cite this as: *BMJ* 2010;341:c5135

bmj.com

- Feature: How market based pricing is failing Indian patients (*BMJ* 2014;348:g278)
- Personal view: India's rejection of Novartis's patent is but a small step in the right direction (*BMJ* 2013;346:f2412)

Patent wars: affordable medicines versus intellectual property rights

In the battle for affordable medicine India has delivered several blows to the drug industry. **Jacqui Wise** reports on how India has inspired other developing countries to challenge the patent system

The pharmaceutical industry is increasingly looking towards emerging markets, where demand for new drugs is rising rapidly alongside rates of chronic disease. But in recent years India, known as the "pharmacy of the developing world," has led the battle for affordable drugs, using legal mechanisms to overturn patents so that its generic drug companies (which produce a fifth of the world's generic drugs) can undercut the Western giants. Developing countries have followed India's example, and battles over patent protection and prices have broken out from

INDIA'S FIGHT FOR AFFORDABLE DRUGS

2001: The Doha declaration on trade related aspects of intellectual property rights (TRIPS) and public health reaffirmed the right to balance public health needs with intellectual property rights

2001: Indian generic company Cipla begins marketing a $1 a day generic combination antiretroviral therapy

2005: India signs the World Trade Organization's TRIPS agreement, which includes a 20 year patent term for medicines

March 2012: India awards first compulsory licence for a generic version of Bayer's cancer drug sorafenib (Nexavar)

April 2013: Indian Supreme Court rules against Novartis, ending seven year battle to patent an updated version of leukaemia drug imatinib

May 2013: India put on the Office of the US Trade Representative's priority watch list

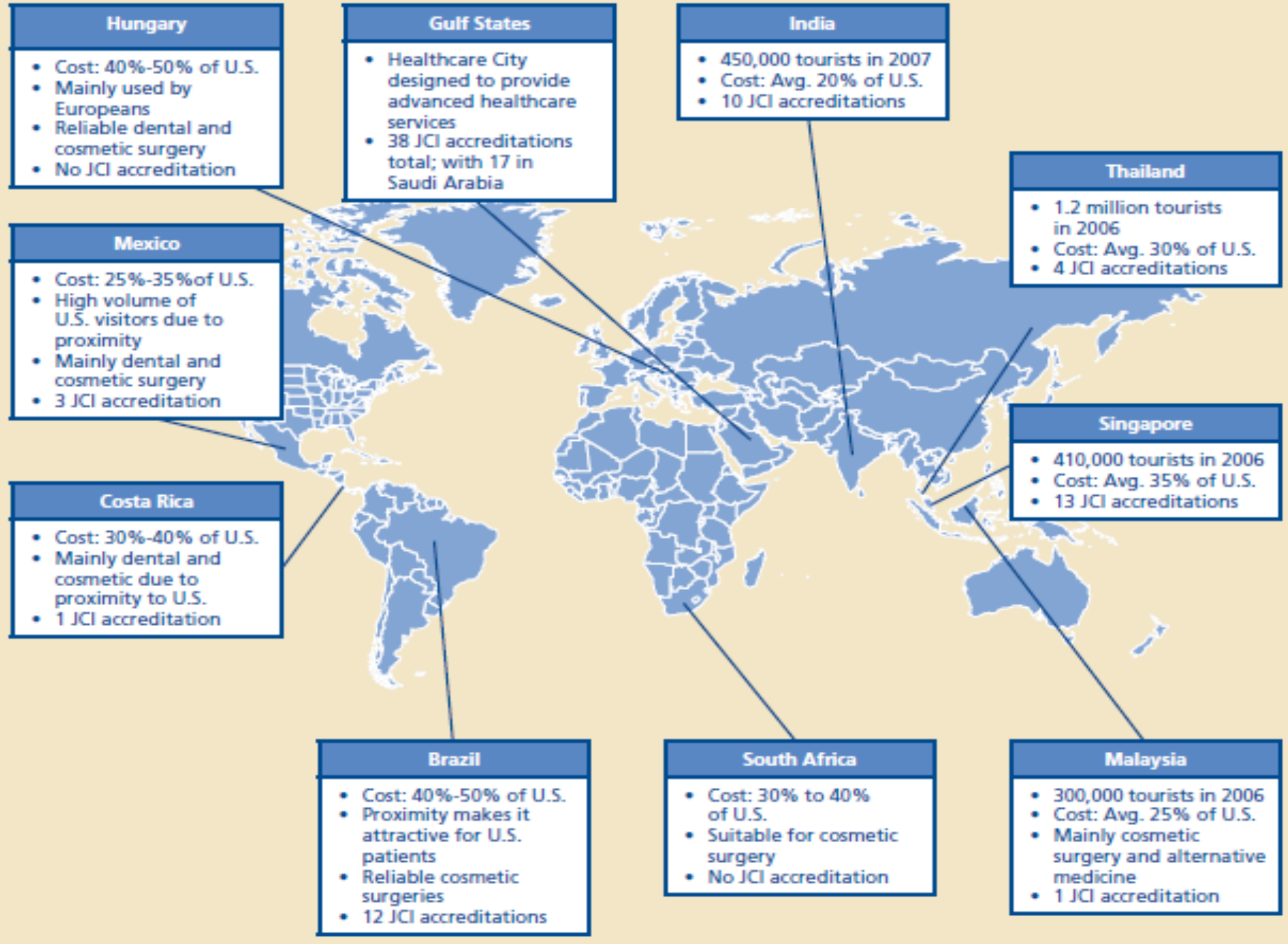
August 2013: Roche decides not to pursue its patent on trastuzumab (Herceptin)

Trade and health *care*

- Increasingly, advances in telecommunications and travel have seen increase in trade in *services*, such as:
  - E-health (service crosses border)
  - Foreign investment (capital crosses border)
  - Migration of health worker (supplier crosses border)
  - Medical tourism (consumer crosses border)

Medical tourism

- > 5 million foreign patients per year
- Global market > $50 billion
- Social, cultural and linguistic factors generate strong regional dimension, especially among bordering countries
  - Singapore/Malaysia patients mostly from ASEAN
  - Cuban patients mostly from Caribbean and Central America
  - Jordanian patients mostly from Yemen, Bahrain, Sudan, Syria, Libya, Palestine and Saudi Arabia


Hungary
• Cost: 40%-50% of U.S.
• Mainly used by Europeans
• Reliable dental and cosmetic surgery
• No JCI accreditation
Gulf States
• Healthcare City designed to provide advanced healthcare services
• 38 JCI accreditations total; with 17 in Saudi Arabia
India
• 450,000 tourists in 2007
• Cost: Avg. 20% of U.S.
• 10 JCI accreditations
Thailand
• 1.2 million tourists in 2006
• Cost: Avg. 30% of U.S.
• 4 JCI accreditations
Mexico
• Cost: 25%-35%of U.S.
• High volume of U.S. visitors due to proximity
• Mainly dental and cosmetic surgery
• 3 JCI accreditation
Singapore
• 410,000 tourists in 2006
• Cost: Avg. 35% of U.S.
• 13 JCI accreditations
Costa Rica
• Cost: 30%-40% of U.S.
• Mainly dental and cosmetic due to proximity to U.S.
• 1 JCI accreditation
Brazil
• Cost: 40%-50% of U.S.
• Proximity makes it attractive for U.S. patients
• Reliable cosmetic surgeries
• 12 JCI accreditations
South Africa
• Cost: 30% to 40% of U.S.
• Suitable for cosmetic surgery
• No JCI accreditation
Malaysia
• 300,000 tourists in 2006
• Cost: Avg. 25% of U.S.
• Mainly cosmetic surgery and alternative medicine
• 1 JCI accreditation

Philippines Medical Center

Live Kidney Donor Transplant in the Phlilippines

- Information about Kidney Transplants
- 24-7 private nursing
- Comfortable environment
- Contact Us

Transplant Package

The Living Donor Transplant package includes the following:

1. Transportation from the airport on the day of the arrival and to the airport on the day of departure
2. Transport, accompanying, and translation by the Company staff during all medical treatments
3. 25 days stay in a clean, respectable, and pleasant three star hotel located in the center of the city five minutes travel from the medical center including breakfast for the patient and the accompanying person of his/her choice. (The room is equipped with a television, mini-bar, and DVD.)
4. As many dialysis treatments as required
5. Hospitalization in the hospital in a large private room including television, DVD, kitchen, refrigerator, and microwave oven.
6. Living donor kidney transplant including drugs
7. Round the clock assigned nurse during the entire hospitalization
8. Anti-rejection drugs for seven days on the departure day

The total price is $85,000 USD.

The package does not include:

1. Flights
2. Medical treatments not related to the kidney transplant and disease, such as heart and other problems

For your convenience, the following is attached: Engagement Agreement for Kidney Transplant

Philippine Medical Centre Ltd.
28/F, Tower 2,
The Enterprise Centre,
6766 Ayala Ave, cor Paseo de Roxas
Macaty City 1226, Philippines
Tel: +63-2-8493953
Fax: +63-2-8865008

Noree et al. Globalization and Health 2014, 10:29
http://www.globalizationandhealth.com/content/10/1/29

GLOBALIZATION AND HEALTH

RESEARCH Open Access

UK medical tourists in Thailand: they are not who you think they are

Thinakorn Noree[1,2], Johanna Hanefeld[1,3*] and Richard Smith[1,4]

- Far smaller market than generally suggested
  - 350,000 foreign patients out of 16m tourists (250,000 of these ex-pat/opportunistic)
- MT/companions spend >twice non-MT
- No difference in care between Thais and foreigners
  - Hospitals employ spare capacity
- MT a 'good thing': add to tourism industry, but take little from domestic health system

OPEN ACCESS Freely available online

PLOS ONE

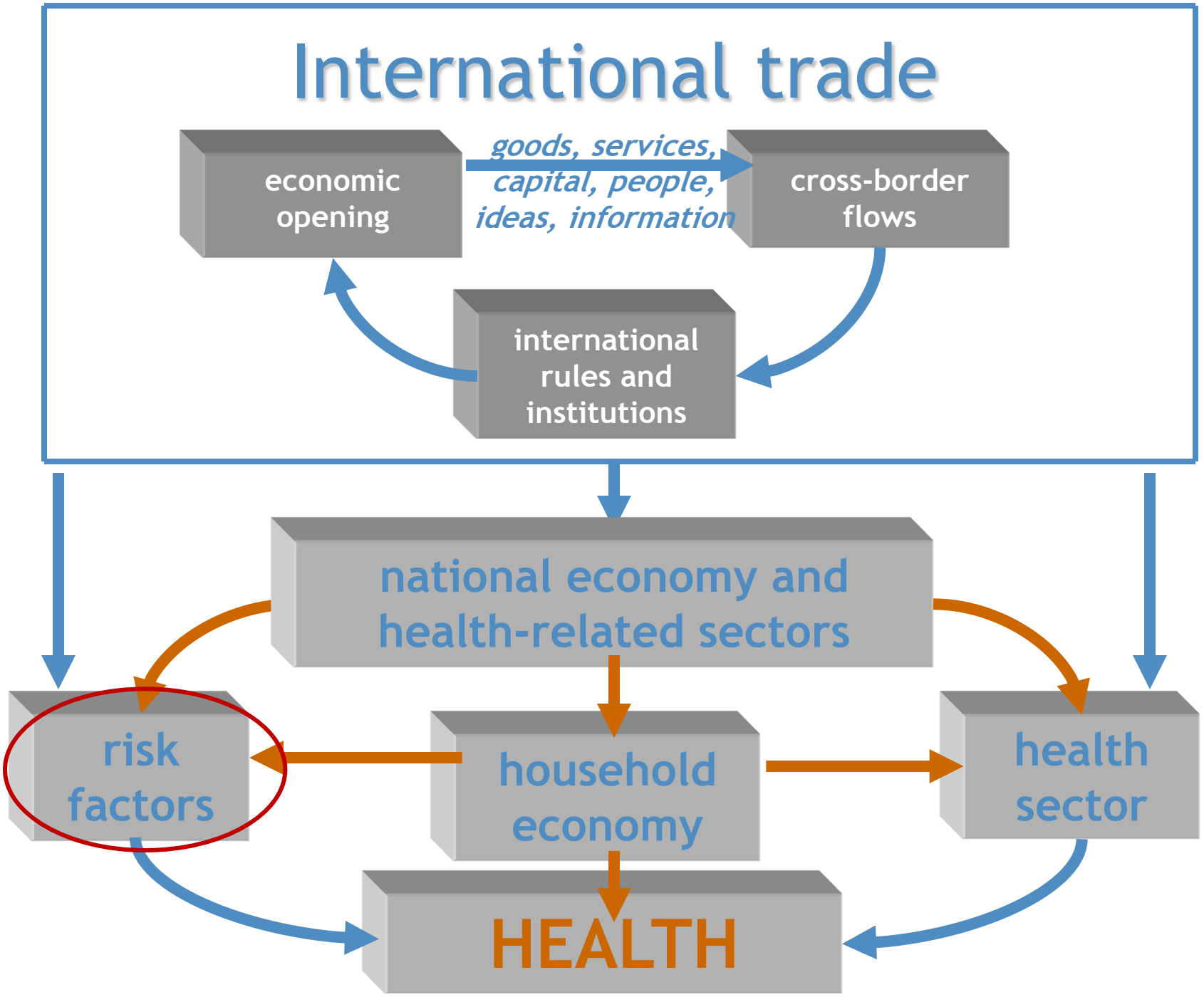
Medical Tourism: A Cost or Benefit to the NHS?

Johanna Hanefeld[1]*, Daniel Horsfall[2], Neil Lunt[2], Richard Smith[3]

1 Department Global Health and Development, Faculty of Public Health and Policy, London School of Hygiene and Tropical Medicine, London, United Kingdom, **2** Department of Social Work and Social Policy, University of York, York, United Kingdom, **3** Faculty of Public Health & Policy, London School of Hygiene & Tropical Medicine, London, United Kingdom

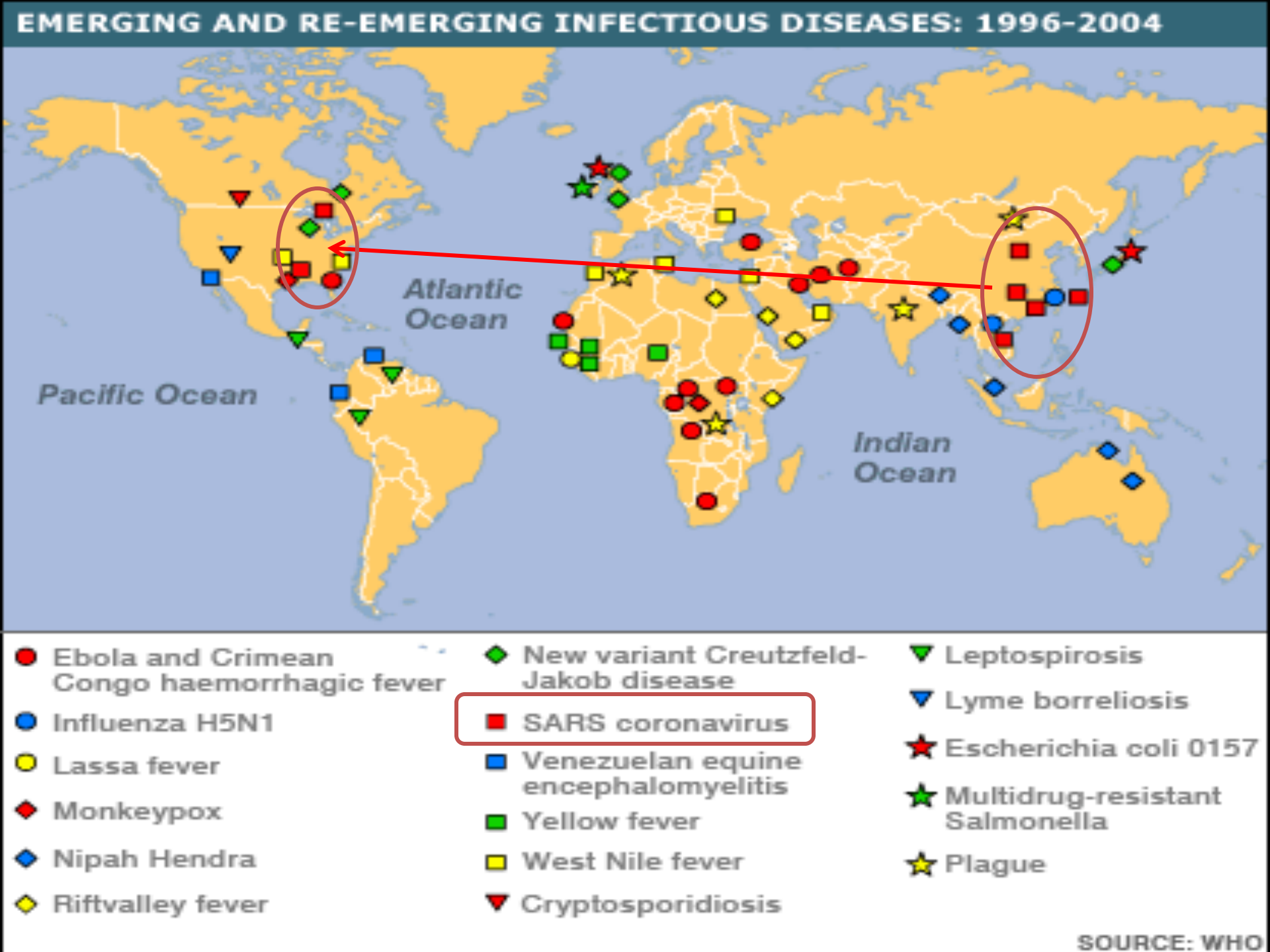
Abstract

'Medical Tourism' – the phenomenon of people travelling abroad to access medical treatment - has received increasing attention in academic and popular media. This paper reports findings from a study examining effect of inbound and outbound medical tourism on the UK NHS, by estimating volume of medical tourism and associated costs and benefits. A mixed methods study it includes analysis of the UK International Passenger Survey (IPS); interviews with 77 returning UK medical tourists, 63 policymakers, NHS managers and medical tourism industry actors policymakers, and a review of published literature. These informed costing of three types of treatments for which patients commonly travel abroad: fertility treatment, cosmetic and bariatric surgery. Costing of inbound tourism relied on data obtained through 28 Freedom-of-Information requests to NHS Foundation Trusts. Findings demonstrate that contrary to some popular media reports, far from being a net importer of patients, the UK is now a clear net exporter of medical travellers. In 2010, an estimated 63,000 UK residents travelled for treatment, while around 52,000 patients sought treatment in the UK. Inbound medical tourists treated as private patients within NHS facilities may be especially profitable when compared to UK private patients, yielding close to a quarter of revenue from only 7% of volume in the data examined. Costs arise where patients travel abroad and return with complications. Analysis also indicates possible savings especially in future health care and social costs averted. These are likely to be specific to procedures and conditions treated. UK medical tourism is a growing phenomenon that presents risks and opportunities to the NHS. To fully understand its implications and guide policy on issues such as NHS global activities and patient safety will require investment in further research and monitoring. Results point to likely impact of medical tourism in other universal public health systems.


International trade
economic opening
goods, services, capital, people, ideas, information
cross-border flows
international rules and institutions
national economy and health-related sectors
risk factors
household economy
health sector
HEALTH

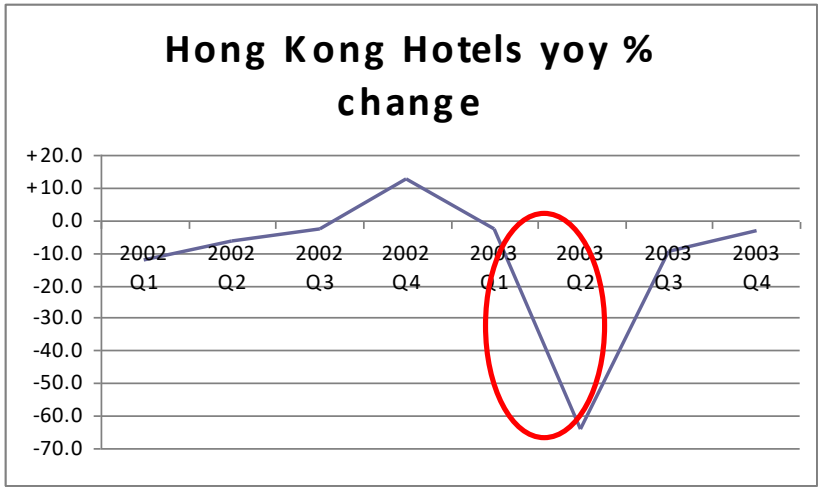
Trade and risk factors

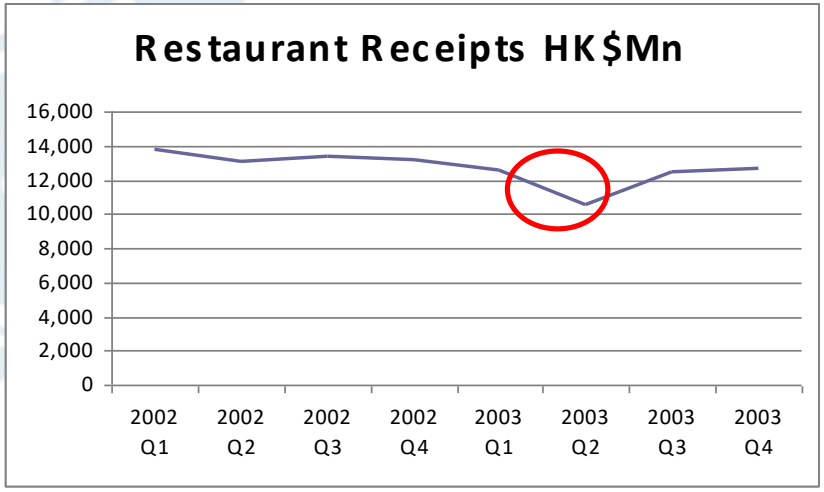
- Trade influences pattern of disease risk…
  - Communicable disease patterns affected by speed of movement of people, animals and goods
  - Non-communicable disease patterns affected by changes in income and marketing/availability
- Globalization can change pattern of response
  - Speed of identification of emergent disease and development/distribution of vaccines
  - Other measures, such as travel advisories etc
- Increasing levels of disease impacts economy

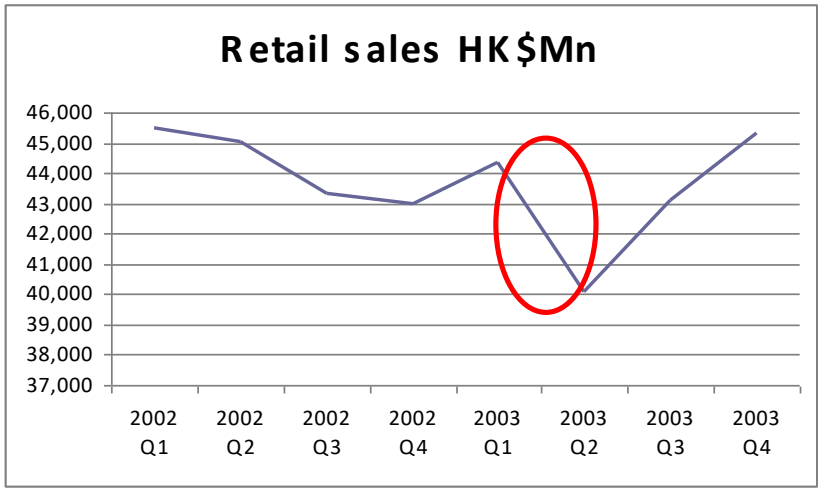

EMERGING AND RE-EMERGING INFECTIOUS DISEASES: 1996-2004
Atlantic Ocean
Pacific Ocean
Indian Ocean
Ebola and Crimean Congo haemorrhagic fever
Influenza H5N1
Lassa fever
Monkeypox
Nipah Hendra
Riftvalley fever
New variant Creutzfeld-Jakob disease
SARS coronavirus
Venezuelan equine encephalomyelitis
Yellow fever
West Nile fever
Cryptosporidiosis
Leptospirosis
Lyme borreliosis
Escherichia coli 0157
Multidrug-resistant Salmonella
Plague
SOURCE: WHO

SARS in Hong Kong

- Health (sector) impact small, but impact on other sectors large
  - E.g. Hong Kong retail losses ~ US$334m







Epidemics damage economies as well as health

Aug 16th 2014 | LAGOS AND LONDON | From the print edition

The Economist

Timekeeper

Keep calm and carry on

ONE of the first casualties of any epidemic is tourism. The outbreak of Ebola in west Africa provides the latest evidence. “The Ebola scare is really affecting bookings,” says Darren Julyse, a manager with a boutique hotel group in Lagos, Nigeria’s largest city and its commercial capital. “A lot of big companies are putting on travel restrictions.”


TIME
The Flu Hunters


nature
AVIAN FLU

BMJ

RESEARCH

The economy-wide impact of pandemic influenza on the UK: a computable general equilibrium modelling experiment

Richard D Smith, professor of health system economics,[1] Marcus R Keogh-Brown, research fellow in economic modelling,[1] Tony Barnett, professorial research fellow and honorary professor,[1,2] Joyce Tait, professor and scientific adviser[3]

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doi:10.1136/bmj.b4571

ABSTRACT

Objectives To estimate the potential economic impact of pandemic influenza, associated behavioural responses, school closures, and vaccination on the United Kingdom.

Design A computable general equilibrium model of the UK economy was specified for various combinations of mortality and morbidity from pandemic influenza, vaccine efficacy, school closures, and prophylactic absenteeism using published data.

Setting The 2004 UK economy (the most up to date available with suitable economic data).

Main outcome measures The economic impact of various scenarios with different pandemic severity, vaccination, school closure, and prophylactic absenteeism specified in terms of gross domestic product, output from different economic sectors, and equivalent variation.

Results The costs related to illness alone ranged between 0.5% and 1.0% of gross domestic product (£8.4bn to £16.8bn) for low fatality scenarios, 3.3% and 4.3% (£55.5bn to £72.3bn) for high fatality scenarios, and

syndrome (2003), H1N1 subtype of the influenza A virus (2009), and sporadic outbreaks of H5N1 influenza subtype.[2] In addition to the direct health impacts of a serious outbreak, we should be concerned about the economic impact; especially at a time of global recession.[3] Preparedness planning for a pandemic must therefore balance two key policy strands—maintaining "business as usual" to minimise the economic impact of a pandemic, and encouraging "social distancing" to minimise the health related impact of a pandemic[4]—as well as using resources such as antivirals and vaccinations.

This paper considers the tension inherent in these two policy strands. It provides evidence of the economy-wide impact of each approach, as well as the impact that vaccine development may have in reconciling the two objectives of minimising both the health and economic effects of a pandemic. A key consideration in this analysis is the role of public perception and confidence, expressed by "prophylactic absenteeism."

DOI:10.1111/irv.12137
www.influenzajournal.com

Original Article

Macroeconomic impact of a mild influenza pandemic and associated policies in Thailand, South Africa and Uganda: a computable general equilibrium analysis

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Accepted 18 April 2013. Published Online 04 July 2013.

Background Previous research has demonstrated the value of macroeconomic analysis of the impact of influenza pandemics. However, previous modelling applications focus on high-income countries and there is a lack of evidence concerning the potential impact of an influenza pandemic on lower- and middle-income countries.

Objectives To estimate the macroeconomic impact of pandemic influenza in Thailand, South Africa and Uganda with particular reference to pandemic (H1N1) 2009.

Methods A single-country whole-economy computable general equilibrium (CGE) model was set up for each of the three countries in question and used to estimate the economic impact of declines in labour attributable to morbidity, mortality and school closure.

Results Overall GDP impacts were less than 1% of GDP for all countries and scenarios. Uganda's losses were proportionally larger than those of Thailand and South Africa. Labour-intensive sectors suffer the largest losses.

Conclusions The economic cost of unavoidable absence in the event of an influenza pandemic could be proportionally larger for low-income countries. The cost of mild pandemics, such as pandemic (H1N1) 2009, appears to be small, but could increase for more severe pandemics and/or pandemics with greater behavioural change and avoidable absence.

Keywords Influenza, macroeconomic modelling, South Africa, Thailand, Uganda.

HEALTH ECONOMICS
Health Econ. **22**: 824–834 (2013)
Published online 19 July 2012 in Wiley Online Library (wileyonlinelibrary.com). DOI: 10.1002/hec.2862

THE ECONOMIC IMPACT OF H1N1 ON MEXICO'S TOURIST AND PORK SECTORS

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Department of Global Health and Development, Faculty of Public Health and Policy, London School of Hygiene and Tropical Medicine, London, UK

SUMMARY

By examining tourist arrivals and pork output and trade statistics, this analysis estimates the economic impact to the Mexican tourism and pork sectors because of the H1N1 influenza pandemic. It also assesses the role of the international response in the context of this economic impact.

For tourism, losing almost a million overseas visitors translated into losses of around $US2.8bn, which extended over a five-month period, mostly because of the slow return of European travellers. For the pork industry, temporal decreases in output were observed in most of the country and related to H1N1 incidence ($p=0.048$, $r=0.37$). By the end of 2009, Mexico had a pork trade deficit of $US27m. The losses derived from this pandemic were clearly influenced by the risk perception created in tourist-supplying and pork trade partners.

Results suggest that the wider economic implications of health-related emergencies can be significant and need to be considered in preparedness planning. For instance, more effective surveillance and data gathering would enable policy to target emergency funding to the sectors and regions hardest hit. These results also stress the importance of being familiar with trade networks so as to be able to anticipate the international response and respond accordingly.

Received 21 July 2011; Revised 20 May 2012; Accepted 20 June 2012

GLOBAL HEALTH

Global Noncommunicable Diseases — Where Worlds Meet

K.M. Venkat Narayan, M.D., Mohammed K. Ali, M.B., Ch.B., and Jeffrey P. Koplan, M.D., M.P.H.

Like climate change, the relentless worldwide spread of noncommunicable diseases offers an opportunity for low-, middle-, and high-income countries to join forces in addressing a major global challenge that threatens health and economies alike. A recent report from the World Health Organization[1] identified six risk factors associated with noncommunicable diseases as the leading global risk factors for death: high blood pressure, tobacco use, high blood glucose levels, physical inactivity, overweight or obesity, and high cholesterol levels. Together, these factors contribute to a large proportion of

situations of individuals, families, and societies. According to the World Economic Forum's 2009 report, noncommunicable diseases are among the most severe threats to global economic development, more likely to be realized and potentially more detrimental than fiscal crises, natural disasters, or pandemic influenza. It is projected that in the next 10 years, China, India, and Britain will lose $558 billion, $237 billion, and $33 billion, respectively, in national income as a result of largely preventable heart disease, strokes, and diabetes.[2,3] In the United States, cardiovascular disease and diabetes

culosis and community-acquired pneumonias — and therefore to the poorer outcomes associated with these complications. Furthermore, owing to burdensome health care costs, disability, absenteeism, and forgone income, noncommunicable diseases result in poverty, thus contributing to a vicious cycle. Because of their multiple interacting causes and complications, as well as their lifelong nature, noncommunicable diseases challenge current paradigms of health care organization and delivery.

Confronted by the ever-increasing threat of such diseases, high-, middle- and low-income coun-

Globalization and food

- Massive expansion of agricultural trade:
  - 1990-2010 increased from $243bn to $467bn
  - 1990-2010, imports into developing countries increased by 115% (45% into developed)
  - 1990-2010, FDI in manufacturing $73-$248bn
- Impacts on food availability, prices & safety
- Impacts on health (+ve *and* –ve):
  - Undernutrition (food availability/price)
  - Diet-related chronic diseases
  - Foodborne disease (food safety)

Health, agricultural, and economic effects of adoption of healthy diet recommendations

Karen Lock, Richard D Smith, Alan D Dangour, Marcus Keogh-Brown, Gessuir Pigatto, Corinna Hawkes, Regina Mara Fisberg, Zaid Chalabi

Transition to diets that are high in saturated fat and sugar has caused a global public health concern, as the pattern of food consumption is a major modifiable risk factor for chronic non-communicable diseases. Although agri-food systems are intimately associated with this transition, agriculture and health sectors are largely disconnected in their priorities, policy, and analysis, with neither side considering the complex inter-relation between agri-trade, patterns of food consumption, health, and development. We show the importance of connection of these perspectives through estimation of the effect of adopting a healthy diet on population health, agricultural production, trade, the economy, and livelihoods, with a computable general equilibrium approach. On the basis of case-studies from the UK and Brazil, we suggest that benefits of a healthy diet policy will vary substantially between different populations, not only because of population dietary intake but also because of agricultural production, trade, and other economic factors.

Lancet 2010; 376: 1699–709

Published Online November 11, 2010 DOI:10.1016/S0140-6736(10)61352-9

See Comment page 1619

See Online/Comment DOI:10.1016/S0140-6736(10)61856-9, and DOI:10.1016/S0140-6736(10)61891-0

This is the second in a Series of five papers about chronic diseases

London School of Hygiene and Tropical Medicine, and Leverhulme Centre for Integrative Research on Agriculture and Health, London, UK (K Lock PhD, Prof R D Smith PhD, A D Dangour PhD, M Keogh-Brown PhD, Z Chalabi PhD); **Universidade Estadual Paulista Julio de Mesquita Filho, Tupã, Brazil** (G Pigatto PhD); **and Faculty of Public Health, University of São Paulo, São Paulo, Brazil** (C Hawkes PhD, R M Fisberg PhD)

Introduction

Profound inequalities in access to food exist between the 1 billion people worldwide who are estimated to be undernourished and the many millions who have over-abundant access to diets that are rich in calories but low in mineral and vitamin density.[1] Concurrently, a transition to diets high in saturated fat (mainly meat and dairy foodstuffs) and sugar, and low in staple foods such as cereals, fruits, and vegetables, is occurring in all but the very poorest of countries.[2,3] This transition is causing global public health concern, because patterns of food consumption are a major modifiable risk factor for three of the most common types of chronic non-communicable diseases: cardiovascular disease, diabetes, and some cancers.[4]

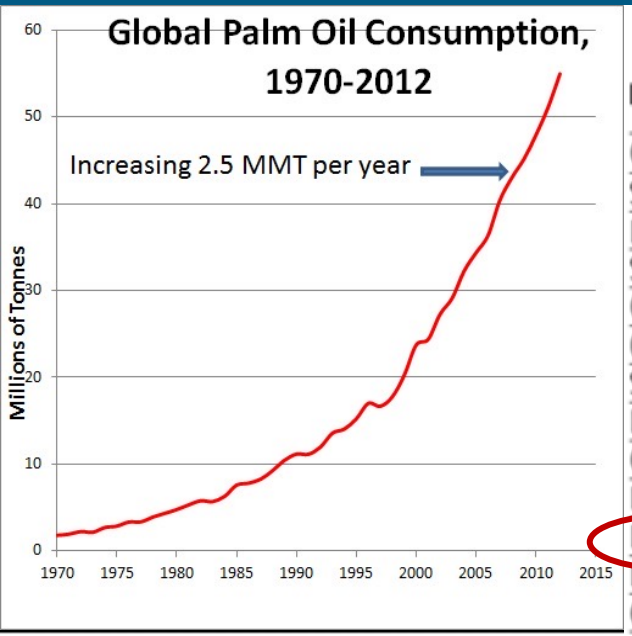
Six risk factors related to nutrition (including high blood pressure, high blood glucose, overweight, and obesity)

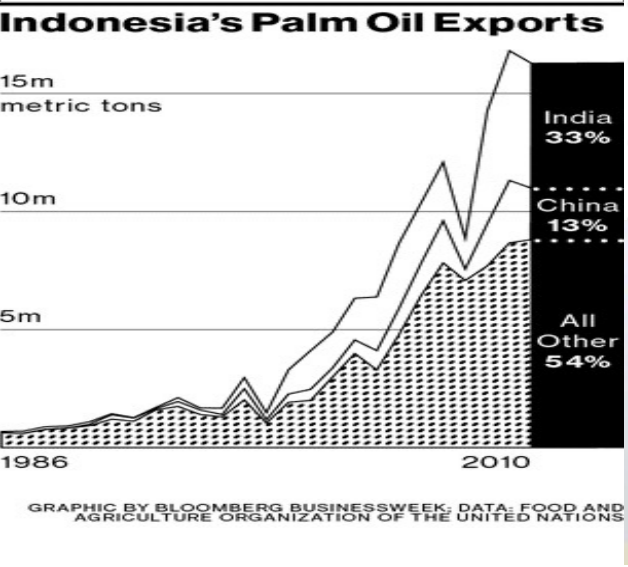
foods. Indeed, agricultural and health sectors are largely disconnected in their priorities and policy objectives. Typically, agricultural priorities centre on production and processing systems, markets, and livelihoods, with concern for food safety only as it affects trade, rather than on broad public health issues. By contrast, public health traditionally centres on agriculture insofar as it affects food security and food safety, with only recent consideration of agriculture's potential role in prevention of non-communicable diseases.[7,10] Neither sector considers the complex inter-relation between agri-trade, food consumption patterns, health, and development.[11,12]

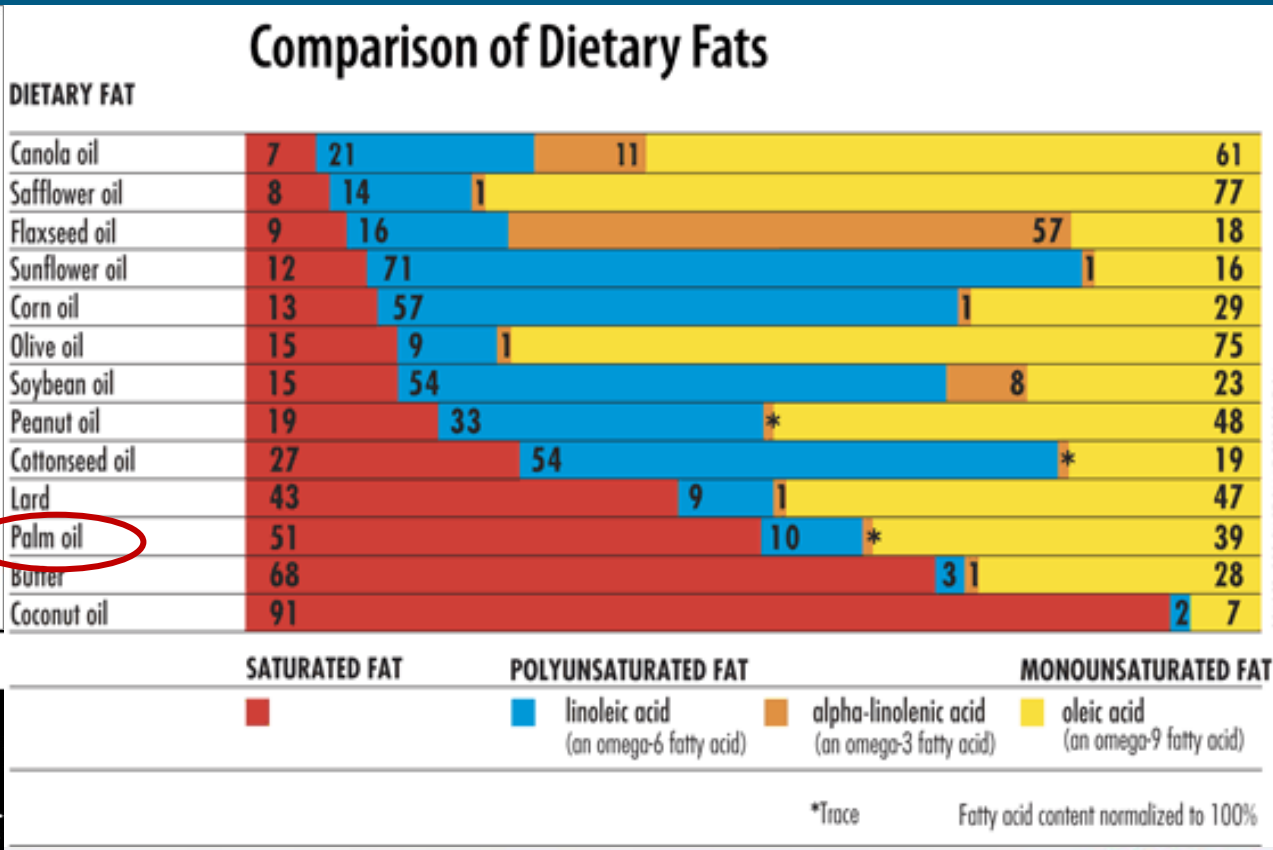
Reduction of the burden of chronic disease through consumption of healthier diets than are consumed at present will probably benefit the health of millions of people, especially the poorest. However, such improvement

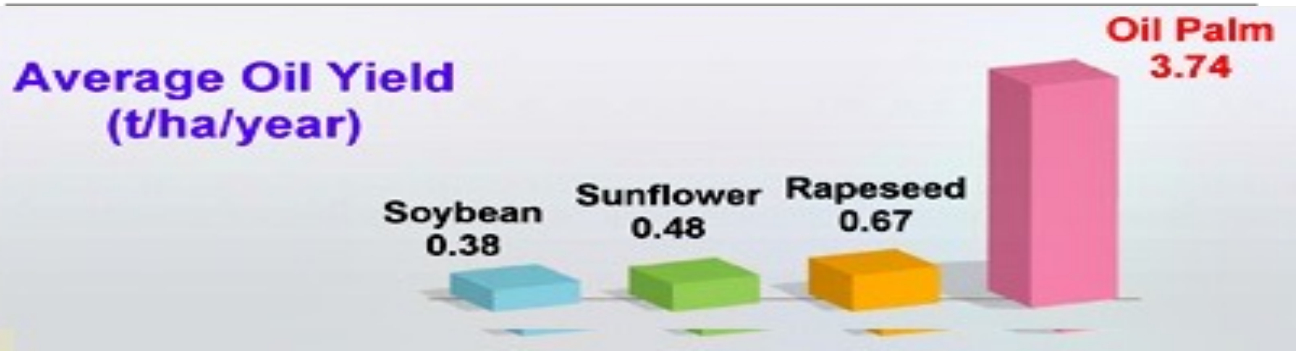
Edible Palm Oil

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE









Schram et al. Globalization and Health (2015) 11:41
DOI 10.1186/s12992-015-0127-7

GLOBALIZATION AND HEALTH

RESEARCH Open Access

The role of trade and investment liberalization in the sugar-sweetened carbonated beverages market: a natural experiment contrasting Vietnam and the Philippines

Ashley Schram[1*], Ronald Labonte[1], Phillip Baker[2], Sharon Friel[2], Aaron Reeves[3] and David Stuckler[3]

Abstract

Background: Trade and investment liberalization may facilitate the spread of sugar-sweetened carbonated beverages (SSCBs), products associated with increased risk factors for obesity, type II diabetes, and cardiovascular diseases (Circulation 121:1356–1364, 2010). Apart from a limited set of comparative cross-national studies, the majority of analyses linking liberalization and the food environment have drawn on case studies and descriptive accounts. The current failure of many countries to reverse the obesity epidemic calls for investigation into both individual and systemic factors, including trade and investment policies.

Methods: Using a natural experimental design we tested whether Vietnam's removal of restrictions on foreign direct investment (FDI) subsequent to its accession to the World Trade Organization in 2007 increased sales of SSCBs compared with a matched country, the Philippines, which acceded in 1995. Difference-in-difference (DID) models were used to test pre/post differences in total SSCB sales and foreign company penetration covering the years 1999–2013.

Results: Following Vietnam's removal of restrictions on FDI, the growth rate of SSCB sales increased to 12.1 % per capita per year from a prior growth rate of 3.3 %. SSCB sales per capita rose significantly faster pre- and post-intervention in Vietnam compared with the control country the Philippines (DID: 4.6 L per annum, 95 % CI: 3.8 to 5.4 L, $p < 0.008$). Vietnam's increase in SSCBs was primarily attributable to products manufactured by foreign companies, whose annual sales growth rates rose from 6.7 to 23.1 %, again unmatched within the Philippines over this period (DID: 12.3 %, 95 % CI: 8.6 to 16.0 %, $p < 0.049$).

Conclusions: Growth of SSCB sales in Vietnam, led by foreign-owned companies, significantly accelerated after trade and investment liberalization.

ANALYSIS

Liberalising agricultural policy for sugar in Europe risks damaging public health

Emilie Aguirre and colleagues discuss what changes to Europe's agricultural policy might mean for our health

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Key messages

- Reforms to the common agriculture policy will lower the commodity price of sugar and liberalise production of high fructose corn syrup in 2017
- These changes have the potential to increase sugar consumption, particularly among the lowest socioeconomic groups
- Europe must explore short to medium term responses to the projected increase of sugars in the food supply such as mandatory reformulation targets and improved monitoring of food content, diet, and health
- In the longer term we should ensure that agricultural policies promote a healthier diet

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How much priority is given to nutrition and health in the EU Common Agricultural Policy?

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ABSTRACT

Agriculture in the European Union (EU) is strongly influenced by the Common Agricultural Policy (CAP). There have been repeated calls for CAP to address nutrition-related health, particularly obesity and non-communicable disease (NCD) in the EU. However, aligning agricultural policy such as CAP with nutrition is complex, not least because the aims of agricultural policy are predominantly economic, presenting a challenge for developing coherence between agricultural trade and health policy. This research examined the political priority given to nutrition-related health concerns within CAP to date, and the solutions suggested by agricultural, trade and health policy-makers and public health nutrition advocates, via interviews of 20 high-level participants from respective sectors. The participants provided diverse perspectives, often varying by sector and institution, on the connections between agricultural policy and nutrition-related health, the extent to which nutrition concerns have been addressed via CAP and whether CAP is an appropriate and effective policy approach to improve nutrition-related health in the EU in the future. The key findings suggest the need for communication and agreement of clear high-level nutrition guidelines, clarity on the EU mandate to address nutrition-related health concerns via policy, and stronger engagement of civil society in the issues if CAP is to address nutrition more than it is doing currently. The difference in worldviews between agricultural/trade representatives, and those from public health, also needs to be addressed.

United Nations System

Standing Committee on Nutrition

EN

Discussion Paper 1

Enhancing Coherence between Trade Policy and Nutrition Action

Implementing the Framework for Action of the Second International Conference on Nutrition

Conclusion

- Increasingly health (care) is affected by events beyond its boundaries/control: wider economy, health-specific trade, disease risk-factors etc
- Health also affects economy, and often it is economic case that speaks to policy makers
- Research, conceptual and methodological developments and policy advice can no longer be viewed purely from a national perspective
- Challenge is to understand the implications of this, and develop and adopt new methods and collaborations to strengthen public health

Public health challenge

- Involvement in *economic* (trade) policy making
  - commitments to health sector trade made with awareness of impact on that sector
  - sufficient protection against increased import of harmful products
  - monitoring key indicators to track implementation and impact of trade policy on health (sector)
- Design of proactive, responsive *health* policy
- Generate economic case to:
  - swing agenda/mobilise resources for prevention
  - identify our allies and our enemies!

THE LANCET

Trade and Health · January, 2009 www.thelancet.com

"The fact that trade directly and indirectly affects the health of the global population with an unrivalled reach and depth undoubtedly makes it a key health issue that the global health community can no longer ignore."