EDITORIAL

GLOBAL POLITICS OF HEALTH: THE DOHA HORIZON

The political context in which social and economic determinants of health operate is familiar in terms of impact of the budget bottom line for public health in each nation-state. Superimposed in the broad picture are estimates of private sector expenditure and insurance costs. On top are imposed the ways in which governments play the consequent games based on public/private sector financial allocations. The immediate political debates whirl around the costs and the benefits in terms of disease management and health promotion. Costs are the key but not necessarily the only endpoint: the whole must fit into a framework that has at least some humanitarian context.

But in reality the political forces with which health must contend are far wider than the health scenario itself. Nor are these forces contained entirely within the confines of the nation-state. They are global in reach and impact. We have been unwitting witnesses to this in the form of the Asian economic crisis of 1997 when sudden devaluation of national currencies in Thailand, Malaysia, Indonesia, Korea disrupted impressive economic growth and with it many of the carefully planned advances in health systems and services. The negative effects of the crisis are still being experienced, even though recovery has been substantial.

One effect of that period was the overt wielding of power by the International Monetary Fund (IMF) and the World Bank (WB), by virtue of their tight handling of overall economic survival/revival policy. The failings of IMF and WB strategies have long been the subject of heated debate (*eg* Caulfield, 1996). Public health systems and other social services were denuded of adequate financial support and at the same time many private health services collapsed due to unsecured capital commitments. This experience underscored the subservience of health structure to macroeconomic policy shifts in general and especially those heavily influenced by these two agencies.

But subsequent events highlighted the growing power of a third international consortium, the World Trade Organization (WTO). Evolving from the General Agreement on Tariffs and Trade (GATT), WTO controls global trade by member states and a wide range of operations related thereto (Wallach and Sforza, 1999). WTO is dominated by rich industrial country economic interests, governed by both government structure and private sector corporations. Poorer countries find themselves in a dilemma: on the one hand wanting to attract corporate investment for industrial expansion in their economies, on the other hand fearing WTO-supported limitation of their exports to richer markets. A major problem is the transience of foreign capital investment, which tends to follow an up and down path, giving rise to market - and hence employment – instability.

This spectrum implies major uncertainties in the health sector in poorer countries at the level of fall-out of macroeconomic strategy uncertainty. But in addition there are some specific health-sector repercussions of the WTO powers. The most troubling is the matter of patents. WTO aims to strictly enforce patent laws in the international arena: while this applies across the board, a particularly tough focus is on therapeutic drug protection. Most medical drugs are manufactured by transnational pharmaceutical corporations and sold globally for profit at high retail cost. While this profit relates in part to the high investment costs in research and development, it means that the poor majority of the world's population cannot afford to buy many life-saving drugs, yet at least some of these can be manufactured at low cost by developing country pharmaceutical industries if patents are ignored. The most dramatic current example of the problem is the anti-HIV category: the majority of AIDS cases

are in Africa but few affected individuals there can afford them, so they die when low cost substitutes manufactured in India or elsewhere could greatly reduce the mortality.

Two interesting developments took place at the most recent WTO meeting in Doha, Qatar in November 2001. First, China was formally approved as a new member of WTO. China's membership brings into the game a giant Asian economy which has both industrialized and poor country attributes, potentially altering the playing field substantially, so that differing scenarios of trade policies and their implications are sure to arise. At least for the moment the mockery of exclusion of the world's largest country from the global trading cabal appears to have ended.

Second, a glimmer of hope arose in relation to pharmaceutical patents. The TRIPS (Trade-Related Aspects of Intellectual Property Rights) Agreement has been a stumbling block to equitable access by least developed countries (LDCs) to essential drugs for a very long time. Until now this Agreement has served the market interests of major world corporations, including the giant pharmaceutical companies, reinforcing the crisis expressed above. At Doha a resolution was passed (WTO TRIPS declaration, 2001) that opened the door marginally to potentially greater justice in this arena:

WTO declaration on the TRIPS agreement and public health adopted 14 November 2001:

1. We recognize the gravity of the public health problems afflicting many developing and least-developed countries, especially those resulting from HIV/AIDS, tuberculosis, malaria and other epidemics.

2. We stress the need for the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) to be part of the wider national and international action to address these problems.

3. We recognize that intellectual property protection is important for the development of new medicines. We also recognize the concerns about its effects on prices.

4. We agree that the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all.

In this connection, we reaffirm the right of WTO Members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose.

5. Accordingly and in the light of paragraph 4 above, while maintaining our commitments in the TRIPS Agreement, we recognize that these flexibilities include:

a. In applying the customary rules of interpretation of public international law, each provision of the TRIPS Agreement shall be read in the light of the object and purpose of the Agreement as expressed, in particular, in its objectives and principles.

b. Each Member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted.

c. Each Member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.

d. The effect of the provisions in the TRIPS Agreement that are relevant to the exhaustion of intellectual property rights is to leave each Member free to establish its own regime for such exhaustion without challenge, subject to the MFN and national treatment provisions of Articles 3 and 4.

6. We recognize that WTO Members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPS Agreement. We instruct the Council for TRIPS to find an expeditious solution to this problem and to report to the General Council before the end of 2002.

7. We reaffirm the commitment of developed-country Members to provide incentives to their enterprises and institutions to promote and encourage technology transfer to least-developed country Members pursuant to Article 66.2. We also agree that the least-developed country Members will not be obliged, with respect to pharmaceutical products, to implement or apply Sections 5 and 7 of Part II of the TRIPS Agreement or to enforce rights provided for under these Sections until 1 January 2016, without prejudice to the right of least-developed country Members to seek other extensions of the transition periods as provided for in Article 66.1 of the TRIPS Agreement. We instruct the Council for TRIPS to take the necessary action to give effect to this pursuant to Article 66.1 of the TRIPS Agreement.

It is only a small opening, still far from acceptable to least developed country members of WTO, as judged from the reaction to the Doha Ministerial declaration (2001) that was finalized behind closed doors by the WTO establishment (Third World Network, 2001).

The problem is the magnitude of fall in price of essential drugs that must occur in a great many countries' markets to make a significant impact on urgent disease problems such as HIV/AIDS, malaria, tuberculosis and many others (Farmer, 2001). What tends to be forgotten in the rich industrialized world is the global nature of the risks of such infections: they do not hide behind the closed doors. Public health is a global enterprise in which all can win if the poorest have equitable access. The Doha resolution is a far cry from the political change needed to ensure golbal parity in management of health and disease, but can it be a significant step forward?

Of course the Doha horizon goes way beyond TRIPS. The unfairness in trade practices on a broad front goes to the heart of the global economy where the rich country dominance is monumental. So much of this economy is beyound the control of nation-states, even if fairness were on their political agendas. The subsidized agricultural output of the European Community and of the US belies their proclaimed virtue in supposedly following a fully free market philosophy. Imbalance in food export practices leads to uncertainty in the agricultural sector, rising unemployment, decreased capital investment, malnutrition, starvation and premature death. The macroeconomic games undermine health on a grand scale.

It remains to be seen whether the still relatively young WHO Commission on Macroeconomics and Health (2001) can make any long term impression on this negative fallout from the political manipulation of trade. *A priori* the Commission is a valiant attempt to address this vast array of neglected issues in the global arena, an arena in which the public health sector has until now been mainly a spectator rather than a major player. The game is tough, very tough, but it must be played professionally to win even small advances at the micro level.

Chev Kidson

REFERENCES

Caufield C. Masters of illusion: the World Bank and the poverty of nations. New York: Henry Holt and Co, 1996.

Doha Ministerial declaration. http//www.wto.org/2001.

Farmer P. Infections and inequalities: the modern plagues. Berkeley: University of California Press, 2001.

Third World Network. http://www.twnside.org.sg/title/rights 1.htm/2001.

Wallach L, Sforza M. Whose trade organization? Washington: Public Citizen, 1999.

WHO Commission on Macroeconomics and Health. http//www.cmhealth.org/2001.

WTO TRIPS Declaration. http://www.wto.org/2001.