THE FTAA: HEALTH HAZARD FOR THE AMERICAS?

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Hearing on Public Health Accountability in International Trade Agreements: Free Trade Area of the Americas (FTAA)

Miami, Florida
November 19, 2003

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Executive Summary

- The Americas face critical threats to health, including: crises in access to health care, water and other vital human services; re-emerging but preventable fatal diseases; the advance of AIDS; and biohazards. Imbalances in wealth and power undermine equity between and within nations. Addressing these crises is a high priority, and requires effective, cooperative international efforts.

- The draft Free Trade Area of the Americas is likely to worsen these problems. Countries' domestic regulations, including those proven effective in advancing and protecting public health, could be challenged before international trade tribunals as unnecessary barriers to trade. Assigning regulatory decisions to trade tribunals violates the democratic obligations and rights of local, state and national elected officials to protect public health.

- The 2002 study by the World Health Organization and the World Trade Organization concluded that trade in health services cannot improve equity unless "regulatory systems are in place and the capacity to implement them is strengthened."

- Sustainable economic development is an important underpinning of population health. Similarly, a healthy population is an important requirement for sustainable economic development.

- The FTAA would facilitate deregulation and privatization of health services and water. Too often health care corporations have undermined national health systems, national economies, and the public's health. Privatizing and deregulating water has resulted in serious harm to population health, through higher prices, decreased access to safe water, and increased water-related illnesses such as cholera.

- International and bilateral trade agreements have eliminated tariffs on tobacco, and maintained high prices for vital medications.

- Standards for licensing and immigration of doctors, nurses and other health professionals are critical to assure that well qualified caregivers are available in every nation. These standards should be set by professional groups and communities, not through trade negotiations.

People's health must be the highest priority in determining trade policies. CPATH recommends 1) excluding health care and water services, and intellectual property rights, from the FTAA, and 2) turning national and international attention to achieving universal access to water, health care services, and affordable medications, and secure, sustainable development.

THE FTAA: HEALTH HAZARD FOR THE AMERICAS

Introduction: the FTAA and Health

Health is both a universal aspiration of all peoples and governments and a marker of the egregious disparities that exist between the developed and developing world. In 2000, at the World Summit for Social Development in Geneva, leaders worldwide committed to attaining universal and equitable access to basic health care, sanitation and drinking water, to protecting health, and to promoting preventive health programs. But too often health and a stable infrastructure of services are considered secondary to formulas for economic growth that may or may not succeed.

Global interdependence is an unquestionable fact of modern life. Economic globalization, accelerated by changes in communication, technology, and transportation, guarantees that trade will increase. At issue is the role that democratically elected public officials, civil society, unregulated trade as well as rules related to trade, will and should play in determining outcomes of economic activity that benefit population health, and how the imperatives of human social and economic development can be integrated.

The Free Trade Area of the Americas (FTAA) proposes to establish rules for trade among 34 nations in the western hemisphere. Its several chapters are intended to facilitate international trade by private corporations, and to reduce regulation, in a number of sectors: agriculture, government procurement, investment, services, and intellectual property rights. They also propose rules for market access, subsidies, settlement of trade disputes, and competition policy.

This paper presents issues and concerns related to the impact of the FTAA on public health and health care in the Americas. The outline is as follows:

I. Overview

Ia. The FTAA, Health and Democracy

The U.S. faces current or pending crises in universal access to health care, water and other vital human services, as do the other nations of the Americas. Imbalances in wealth and power undermine equity between and within nations. Threats include re-emerging but preventable fatal diseases, the advance of AIDS, and biohazards. Addressing these crises is a high priority, and requires effective, cooperative international efforts.

WTO Agreements and Public Health, a joint study by the World Health Organization (WHO) and the World Trade Organization (WTO) secretariat, concluded in 2002 that trade in health services cannot improve equity unless "regulatory systems are in place and the capacity to implement them is strengthened."[1]

Public health measures have been responsible for creating and monitoring the conditions that maintain a healthy population, from access to safe housing, food and water, to assessing and preventing exposure to biohazards and to dangerous substances such as tobacco. The safety of our work places, living spaces, prescription drugs, and consumer products, as well as near-universal vaccination and many other major health accomplishments, are products of government action, legislation and regulation, not the result of unregulated market forces.

The FTAA proposes to establish rules for trade among 34 nations in the western hemisphere. The agreement would impose trade rules at the regional level of the Americas, in broad areas of concern for health. Many of these areas are already under discussion, and matters of controversy, at the global level, through World Trade Organization agreements such as the General Agreement on Trade in Services (GATS), the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), and the Agreement on Sanitary and Phytosanitary Measures (SPS). FTAA chapters directly related to health cover trade in services, including vital human services such as health care, water, education and energy; intellectual property, which addresses access to affordable medications; standards for the safety of plants and food; and rules on how governments procure goods and services, and allocate subsidies. In addition, FTAA rules that affect health indirectly, by determining nations' economic policies, appear in chapters in financial investments and the terms of trade in products.

The FTAA equates government regulations and public services with barriers to trade such as tariffs. Domestic regulations, including those proven effective in protecting and advancing public health, could be challenged before international trade tribunals as unnecessary barriers to trade. As under the foreign investment chapter (Chapter 11) of the North American Free Trade agreement (NAFTA), investor rights provisions give private companies the ability to challenge laws and regulations adopted by democratically elected governments and officials, seeking compensation for loss of current and future profits.

Ib. Liberalizing trade in services: summary of the arguments pro and con

Liberalizing trade in services is often justified on the basis of four key arguments. A summary of these arguments, addressed at greater length below, includes:

- **Justification A:** Free trade improves economic wealth and therefore health
  Response A:
  1. Economic growth and wealth are important underpinnings of population health and wellbeing. However, under the current rules, global trade has not improved economic growth, or increased wealth for most people in Latin America. In Canada and the U.S., economic benefits from trade are concentrated on large businesses and individuals who are already wealthy.

  2. Recent studies suggest that health is necessary to improve economic wealth.

  3. Protecting population health requires adequate funding for public health systems and universal coverage for personal medical care. Deregulation and privatization of health care have weakened public systems, accountability and health.

4. Safeguarding health includes assuring access to affordable medications, protection from harmful substances such as tobacco and alcohol, and effective standards for patient safety and for licensing health care professionals. All of these areas are weakened by trade agreements.

- **Justification B: Trade in health care presents economic opportunities for developing countries.**
  Response B: There is already substantial trade in health services among nations in the hemisphere. Commercial activity predominantly benefits individual and corporate wealth, at the expense of social objectives such as expanded primary care systems. **The net impact of globalization on population health will depend on the ability of each country to manage trade, including its regulatory environment.**

- **Justification C. Private health insurance can reduce public expenditures for health, making systems more efficient.**
  Response C: Affiliates of U.S. health insurance companies established significant presence in Latin America starting in the mid-1990s. The resulting privatization of formerly public health systems has diverted funds and other resources from critical health needs to administration.[2] Co-payments and other mechanisms have driven up the cost of care, increasing family spending on health care, and presenting barriers to access.

- **Justification D. Privatization of water can expand access to water in developing countries, and control costs in developed countries.**
  Response D:. Multi-disciplinary fact-finding missions and in-depth case studies have concluded that privatizing and deregulating water generally result in harm to population health, through higher prices for water, and increased water-related illnesses such as cholera.

Ic. Recommendations: CPATH supports the Call for Public Health Accountability in International Trade Agreements, which recommends:

1. Assure that health takes priority over commercial interests.
2. Call for an assessment of the impact of the FTAA and GATS on population health, and assure based on such assessment that these agreements do not have an adverse impact on health.
3. Exclude vital human services such as health care and water, and intellectual property rules that affect affordable medications, from trade negotiations and challenge under the FTAA.
4. Include public health representatives in the negotiating advisory process, and promote transparency and democratic accountability at all levels of trade negotiations.
5. Support enforceable commitments to advancing population health, and to achieving universal access to health care, affordable medications, and safe, affordable water in the U.S. and internationally.

II. Deregulating trade in services: a new concept

Until very recently, liberalization of trade was understood to mean reducing financial measures such as tariffs that are alleged to discourage competitive trade from foreign producers. These tariffs essentially add a tax to foreign goods or services, making them more expensive than domestic products. They are intended to protect domestic industries, and encourage the sale of domestically produced products, by artificially imposing higher prices for imported goods. Tariffs have thus been viewed as barriers to international trade, and limits to competition. Economists have varying views on the whether these protectionist policies ultimately benefit domestic and international economic growth.

Many aspects of government regulation, on the other hand, have been commonly understood to play a positive role in economic growth. Whether through assuring common rules and a level playing field

for commerce, providing vital human and social services such as health care, education, and water, or protecting the commons through national parks and clean air standards, public sector accountability has been understood as a necessary basis for economic development. Public health has been responsible for creating and monitoring the conditions that maintain a healthy population, from access to safe housing, food and water, to assessing and preventing exposure to biohazards. The safety of our work places, living spaces, prescription drugs, and consumer products, as well as near-universal vaccination and many other major health accomplishments, are products of government action, legislation and regulation, not the result of unregulated market forces.

There is growing consensus among economists that while markets are very important for a successful economy, there is also an important role for the state. [3] **For example, Nobel-winning economist Joseph Stiglitz recently cited Brazil's strong regulatory policies as a reason for that country's successful handling of its electricity crisis, "while the US let market forces (and companies like Enron) handle the matter."**[4]

The FTAA: Wide Range of Laws and Services Covered, Public Services at Risk

The Free Trade Area of the Americas (FTAA) would change the equation. FTAA equates government regulations and public services with barriers to trade such as tariffs. The FTAA would require governments to publish annually every "measure" relating to services at the national, regional or local level. The FTAA defines a "measure" in Article 8 of the Services chapter as:

> all laws, regulations and administrative directives, decisions, resolutions, rulings, and/or measures of general application that affect the operation of the provisions of [Services] enacted by federal, central and state governments or by non-governmental regulatory agencies.

As under the foreign investment chapter (Chapter 11) of the North American Free Trade agreement (NAFTA), private companies can challenge laws and regulations adopted by democratically elected governments and officials. Any "measure" is subject to elimination if it is shown that it is not "necessary," or is "unduly burdensome to trade." The determination is made by a trade tribunal staffed by unaccountable appointees, which meets behind closed doors. As the FTAA is currently drafted, this process could not be easily challenged based on public health and other considerations.

The FTAA could apply to public services. It defines services generally as "any service of any sector." It excludes services supplied in the exercise of governmental authority, but states that these must be supplied "neither on a commercial basis, nor in competition with one or more service providers." **No vital human service in the U.S. would be exempted under these definitions, including health care and water.** All services would be subject to privatization and deregulation, purportedly in the interest of reducing the barriers to trade in services that are presented by public sector provision of services and by regulation.

These directives would be unsettling even if it were clear how the FTAA is defining "necessary," "burdensome," and "service." It is not clear, however. In January, 2002, the WHO convened a meeting to establish an agenda for research and monitoring on trade in health services, and both WHO and the Pan American Health Organization have made efforts to develop a common approach to understanding health care systems. But there is not yet even a common international language to discuss and measure health status, health care systems, trade in health services, or the effects of each on economic and personal wellbeing.[5]

Modes of trade in services

Following the model of the GATS, the FTAA identifies four modes of trade in services, and addresses barriers to trade in each mode. Each of the following modes is relevant to trade in health care services:

1. Cross-border delivery: Services originating in one region are provided to consumers in another region. A common example is telemedicine, allowing physicians in country A to evaluate a patient located in country B. Activity in the area is relatively low.

2. Consumption abroad: Users of services travel from country A to receive services in country B. Integrating health insurance systems across countries is proposed to facilitate further commerce in this area.

3 Commercial presence: Foreign direct investment (FDI) by a company in country A to provide services in country B. FDI in health care has been restricted or prohibited in many developing countries, where health care is considered a public good, but activity by U.S. insurance companies has increased in the last decade.

4. Movement of natural persons. The movement of trained health care professionals, generally from less developed to more developed nations, is an important issue.

Privatization, Targeting, Decentralization of Services

In Latin America, the World Bank and Inter-American Development Bank have sponsored generations of health sector reforms for the last two decades, aimed at commodifying health services. These services are then considered to be provided on a commercial basis and in competition with other suppliers. Most of these reforms have consisted to one degree or another of a standard menu of three strategies: **privatization, targeting and decentralization**. Under the FTAA, these processes are likely to be accelerated and would mean that health services could not be excluded from the "services" covered in the FTAA.

Privatization refers to the policy of raising revenues for health care through user fees or copayments, and also to divestiture of state ownership in social security health services and opening these services to competition from private companies.

Targeting is intended to focus remaining health subsidies to ensure that programs reach the poorest of the poor. In practice, targeting creates a two-tiered system: people who can afford to pay for services receive one level of health care, while those who cannot receive a much more basic package and sometimes none at all.

Decentralization refers to bringing administrative and financial procedures to the state and local level. Decentralization and deregulation often exacerbate inequities among wealthy and poorer regions in financing and providing health care. The enormous disparities in wealth and services among regions and localities in Peru, discussed below, provide one example.[6]

In summary, the FTAA is alarming to the public health community, which has effectively used regulations and public funding to advance population health as well as economic development.

It is also disturbing to the California legislature, which approved Senate Joint Resolution 40 on August 20, 2002, memorializing Congress, the President, and the United States Trade Representative regarding concerns in the California Legislature with international investment agreements such as Chapter 11 of

NAFTA. This resolution serves as a strong statement from the California legislature that investment agreements such as Chapter 11 threaten democracy and should not be included in future trade agreements such as the GATS and the FTAA.[7]

Refocus International Cooperation on Improving Health

National and international bodies are only beginning to grapple with effective methods for international cooperation on critical threats to health in both developed and developing nations. The National Academy of Sciences enumerated some of these threats in 1997, which include: epidemics of water-related diseases such as malaria and cholera, preventable by providing universal, affordable access to safe water and sanitation; containing the spread of tuberculosis and AIDS; emerging drug resistant diseases; biohazards; international trade in illegal products; lax enforcement of tobacco regulations, including tariffs; income inequality and financial instability; depletion of natural resources; and global warming.

As international trade and international financial institutions increasingly influence public health, it is critical that contending priorities are carefully considered and evaluated. In 1996 the World Bank lending portfolio was $13.5 billion,* compared with the World Health Organization's budget of $400 million. There is a clear need to protect population health, public health systems, and access to vital human services such as water and sanitation, as trade and economic policy are determined.

III. Access to health, health care and water: universal rights

Health is both a universal aspiration of all peoples and governments and a marker of the egregious disparities that exist between the so-called developed and developing world. In Latin America, the region of the world with the greatest disparities between rich and poor, differences in health indicators between rich and poor within countries are also especially notable. Health is increasingly recognized to be a matter of economic development, and these disparities are seen as obstacles to sustainable development.

The fourth trade ministerial of the Summit of the Americas (the San Jose Ministerial) in March, 1998, called upon the FTAA to contribute to raising living standards, to improve the working conditions of all people in the Americas, and to protect the environment.

In 2000, the World Summit for Social Development convened in Geneva to review the principles adopted in Copenhagen in 1995. **The heads of state of the U.S. and other nations** in the Americas and other continents **committed to "give the highest priority to the promotion of social progress, justice and the betterment of the human condition,"** to creating a framework for action to "place people at the center of development and direct our economies to meet human needs more effectively," and to "promote equitable distribution of income and greater access to resources through equity and equality of opportunity for all." Specific commitments included a global drive to "create an economic, political, social, cultural and legal environment that will enable people to achieve social development."

In particular, the leaders committed on the national level to attaining universal and equitable access to basic health care, sanitation and drinking water, to protecting health, and to promoting preventive health programs. The FTAA could subject national sovereignty to accomplish these critical goals to challenge by private corporations.

* All monetary figures denoted by "$" are in U.S. dollars.

At the international level, the leaders called on international financial institutions to integrate these objectives into their policy programs and operations.

The contribution of economics to health issues gained world-wide attention after the release of a report by the Commission on Macroeconomics and Health (CMH),[8] commissioned by the World Health Organization (WHO) and prepared by leading international figures in the field. The CMH report concludes that in order to provide essential medical goods and services to the 2.5 billion people who do not have access to these currently will require an annual investment of $163 billion by 2007. It points out that these sums represent a justified and manageable increase in annual donor funding by developed nations. It also argues that not only does poverty produce ill-health but disease produces poverty, especially because early ill-health affects future productivity. The CMH report estimates that the investment proposed could not only save 8 million lives a year by the end of the decade but that the savings in morbidity and mortality would equal an economic gain of $186 billion a year.[9]

Health is also increasingly recognized as a matter of basic dignity and rights. The major provisions relating to the right to health under international law refer to some formulation of the right as being to "the highest attainable standard of physical and mental health."[10] This formulation does not set out a right to "be healthy;" but it recognizes that the state has a role to play in ensuring an even playing field and providing all people in its territories with the basic conditions and health care necessary for promoting their own health and well-being. The second part of the international provisions generally establish steps governments must take to ensure the right to health.

The right to health is set out in a number of international treaties to which virtually all of the countries in the region are parties, except the United States, including: the International Covenant on Economic, Social and Cultural Rights (ICESCR); the Convention on the Rights of the Child (the Children's Convention); the Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention); the Convention on the Elimination of All Forms of Racial Discrimination (Race Convention); the Protocol of San Salvador to the American Convention on Human Rights; and Convention 169 of the International Labor Organization. A review of these international instruments makes it clear that the right to health as it is enshrined in international law extends well beyond health care services. Indeed, fulfillment of the right to health has been interpreted as implying multi-sectoral action to provide basic conditions necessary for health such as water and sanitation, and environmental health and safety; popular participation in decisions regarding their health, such as the organization of insurance systems; and recourse in the event of violations. Nations' compliance with these international agreements would be affected and potentially jeopardized by the FTAA.

IV. Conditions in the Americas: Inequalities in health and wealth

The U.S. and Canada are the only developed nations in the Americas. As Table 1 illustrates, there are wide differences in per capita income, social expenditures on health services, and health status, within the region. There are also likely differences in benefits and consequences of trade between developed and developing nations.

The growth in the early 1990's in most of the region might be characterized as a respite from the recession of the 1980's and the recessions of the late 1990's, in which per capita incomes have declined in almost every country. Economic growth in the 1990's has only narrowly exceeded that in the 1950's and 1960's, long before free market reforms, and this growth has not been shared by the vast majority of the populations of the countries in Latin America. [11] Inequality within countries has increased dramatically during the last twenty years of structural adjustment programs. The United

Nations Development Programme reports that in Brazil "the poorest 50% of the population received 18% of national income in 1960, falling to 11.6% in 1995. The richest 10% received 54% of the national income in 1960, rising to 63% in 1995."[12] Most countries in Latin America are also burdened with immense foreign debts. For example, in Nicaragua, the total external debt is as high as 306% of the gross national product.[13] At the same time, the International Monetary Fund's austerity programs have crippled the governments' abilities to alleviate the worst effects of poverty and inequality, as has been most keenly demonstrated recently in Argentina.

Table 1. Income, expenditures on health, infant mortality in the Americas, 1998

COUNTRY	Gross National Income Per Cap Current U.S. $ [1]	Expenditures Per Cap on Health Svcs latest year current US$[3]	Health Expenditures % of GDP [2]	Infant Mortality Per 1,000 births[3]
Developed:				
Canada	$21,130	$1,847	9.3%	6
United States	34,100	4,055	12.9	7
Developing:				
Antigua & Barbados	9,440	498	1.9	17
Argentina	7,460	667	8.4	19
Bahamas	14,960	778	4.3	18
Belize	3,110	170	2.7	35
Bolivia	990	53	6.5	66
Brazil	3,580	320	6.5	36
Chile	4,590	369	5.9	11
Columbia	2,020	226	9.4	25
Costa Rica	3,810	245	6.7	14
Cuba		138	9.1	7
Dominican Republic	2,130	126	4.8	43
Ecuador	1,210	59	3.6	30
El Salvador	2,000	164	7.2	30
Guatemala	1,680	78	4.4	41
Guyana	860	45	5.4	58
Haiti	510	16	4.2	91
Honduras	860	56	8.6	33
Jamaica	2,610	159	5.5	10
Mexico	5,070	234	5.3	28
Nicaragua	400	53	12.5	39
Panama	3,260	255	7.3	18
Paraguay	1,440	120	5.2	27
Peru	2,080	100	6.2	43
St Kitts and Nevis	6,570	349	5.8	30
St Vincent & Grenadines	2,720	170	6.3	(not available)
Suriname	1,890	140	6.3	28
Trinidad & Tobago	4,930	248	4.3	16
Uruguay	6,000	697	9.1	16
Venezuela	4,310	200	4.2	21

1 http://devdata.worldbank.org/external/dgcomp.asp?rmdk=110&smdk=473880&w=0

2 http://who.int./whr/2001/main/en/annex/Annex5-en-WEB.xls 1998

3 http://www.socwatch.org.uy/indicators/query.htm 1998

V. Peru: Case study of inequality driven by policy

The differences in indicators among countries is startling, such as maternal mortality ratios (not listed above) in Nicaragua, Haiti, or Bolivia which are 60 to 70 times as high as in the US or Canada. However, national averages are not sufficient to convey the realities of most Latin American countries nor the effects that the FTAA is likely to have. For example, in Peru 47.2% of the population lives in rural and peri-urban settings and in 16 out of 24 departments the rural and peri-urban dwellers constitute a greater percentage of the population than urban dwellers.[14] The disparities in health indices between urban and rural areas (the Demographic and Health Survey, or DHS, does not disaggregate for peri-urban areas) are alarming. According to the DHS 2000, infant mortality was estimated at 28 per 1000 live births in urban areas, and 60 in rural areas. [15] In Metropolitan Lima infant mortality is 17 per1000 live births, while in the Andean province of Huancavelica it is 84.[16]

The differences in maternal and under-five mortality are even starker. For example in urban areas the under-five mortality is 39 per 1000 live births while in rural areas it is 85, and Metropolitan Lima has a rate of 23 per 1000 live births in comparison with the Andean departments of Huánuco y Huancavelica with rates of 108. A confluence of factors produces these enormous disparities in health indices, including: lack of access to medical services; lack of education; lack of adequate living conditions; lack of drinking water and basic sanitation; and lack of food security. These factors are likely to be exacerbated by the deregulation of health services rather than improved.

Moreover, health expenditures in Peru continue to be, even according to the World Bank, "low by any standard."[17] In 1997, health expenditures represented only 4.1% of GDP, whereas the average for Latin America lies between 5.5 and 7.3%. Per capita expenditures on health in 1990 and 1997 are also about half the regional average.[18] Although the Peruvian Ministry of Health (MINSA), the Peruvian Social Security Institute and households have increased their spending since 1994, these numbers are very low.

However, the most troubling aspect of health care financing in Peru is that there continue to be enormous inequalities in the use of health care services. According to the World Bank, per capita use of health services and goods is approximately 4.5 times higher among the richest quintile than among the poorest.[19] MINSA, which in theory serves the poor, is in effect not off-setting the differences in private, out-of–pocket expenditures by the population**.**

For example, although MINSA subsidizes service charges, almost all drugs and medical inputs are charged to the user at full cost plus a mark-up. Drugs and medical inputs constitute 71% of direct health expenditures across the population and 81% of direct expenditures for the poorer two quintiles.[20] The World Bank, itself a supporter of user fees, points to flaws in the system of exception for the poor. First, there is no subsidization of drugs and inputs at the provider level which makes the provider discourage exemptions. Moreover, there is no national or regional fund to subsidize health facilities that serve poor clients so all exemptions are financed out of local generosity. Finally and incredibly, there are no standard criteria to identify the poor. Each individual facility develops its own rules, which are subjectively applied. The World Bank reports that half of the exemptions and fee reductions are actually given to the richer 60% of households.[21]

In short, there is a significant bias in favor of the rich in the provision of health benefits, which would seem to call for government intervention, not further deregulation.[22] However, the FTAA would limit the ability of the Peruvian government to regulate its own health services to remedy inequities if a trade tribunal determined such regulation or legislation was "unduly burdensome to trade."

VI. Justifications for liberalizing trade in services, and counter-arguments

Chanda[23] and others[24] have identified some possible positive and negative effects of trade in health care and water services, and of privatization and deregulation. On balance, the evidence suggests that protection of population health requires careful monitoring of the effects of trade, and accountable government policy. The following sections delineate proposed positive effects, and countervailing considerations.

Justification A: Free trade improves economic wealth and therefore health

Response A:
1. Economic growth and wealth are important underpinnings of population health and wellbeing. However, under the current rules, global trade has not improved economic growth, or increased wealth for most people in Latin America. In Canada and the U.S., economic benefits from "free" trade are concentrated on large businesses and individuals who are already wealthy.

Under structural adjustment policies that prescribe high interest rates and social austerity, Latin American economies grew during the 1990s at half the rate they experienced during the 1960s.[25] Eleven million more Latin Americans lived in poverty at the end of the 1990s than at the beginning of the decade.

Under NAFTA, economic activity increased in both Mexico and the U.S., but workers did not benefit in either country.[26] In Mexico, while foreign direct investment, maquiladora employment, productivity, and exports to the U.S. all increased, the real value of the minimum wage dropped nearly 18%, while manufacturing wages dropped nearly 21%. The total number of Mexicans living in poverty increased from 51% in 1994 to 58.4% in 1998.

The U.S. has experienced a corresponding trade deficit, displacing hundreds of thousands of U.S. jobs. Real wages have lagged far behind productivity, even in the recent economic boom, as workers and unions lost out to threats by highly mobile corporations to move abroad.

In Canada, the manufacturing sector declined by 13% between the time of its first free trade agreement with the U.S. in 1988 and 1996. Disparities have mushroomed, and social programs have been reduced. The income gap between the top and bottom 10% rose from 50 to 1, to 314 to 1. The percent of unemployed Canadians covered by unemployment insurance dropped from 75% in 1989 to about 36% in 2000.

2. Recent studies suggest that health is necessary to improve economic wealth.

The World Health Organization's Commission on Macroeconomics and Health concluded that the health of a population is associated with and can be a precursor for nations' abilities to expand economically.

3. Protecting population health requires adequate funding for public health systems and universal coverage for individual medical care. Deregulation and privatization of health care have weakened public systems and accountability. New and preventable illnesses are emerging in the Americas.

Since 1990 Latin America has suffered epidemics of illnesses that had been eliminated, or never appeared before, including cholera, leptospirosis, dengue, hanta virus and typhoid.[27] Dengue hemorrhagic fever (DHF) is a potentially lethal complication of dengue infection. Dengue is carried by mosquitoes, and can be controlled only by safe water storage. Relatively contained before 1970, dengue is now endemic in more than 100 tropical and sub-tropical countries, almost half of which have experienced DHF epidemics. In 2001, there were 150,000 cases of DHF in the Americas, including explosive outbreaks in Brazil.[28] In 2002, fatal cases of both dengue and DHF were reported in Ecuador, El Salvador, Honduras, and Brazil. The first reported detection of dengue fever in the Galapagos Islands occurred in August, 2002.[29]

Health status in the U.S. is also increasingly compromised by the high percent of residents without health insurance, and consequently with poor access to care. Recent figures show that hospitalizations are increasing for conditions that could be prevented by timely ambulatory care.[30]

4. Safeguarding health includes assuring access to affordable medications, protection from harmful substances such as tobacco and alcohol, and effective standards for patient safety and for licensing health care professionals. All of these areas are weakened by trade agreements.

A report published by the Pan American Health Organization noted that, "The increasingly global production and marketing of cigarettes has a major adverse health impact. Transnational tobacco companies…have been among the strongest proponents of tariff reduction and open markets. Trade openness is linked to tobacco consumption."[31]

Justification B. Trade in health care presents economic opportunities for developing countries.

Response B:
There is already substantial trade in health services among nations in the hemisphere. Commercial activity presently benefits individual and corporate wealth, at the expense of social objectives such as expanded primary care systems. **The net impact of globalization on population health will depend on the ability of each country to manage trade, including its regulatory environment.**

Niche markets
Some developing countries have created niche markets to provide high quality specialized health services at lower cost than in developed countries, and that therefore attract foreign users. These include Cuba (which is not covered by the FTAA), Jordan, India, and Tunisia, and China for traditional therapies. There is little evidence, however, that revenues generated by niche markets are channeled to improve the domestic infrastructure and systems for providing medical care and public health services.

In fact, greater economic activity in commercial health care services does not necessarily result in any net economic benefit to national economies or to the population. Niche marketing of specialty services exacerbates two-tier systems, and drains resources away from public health.

In Latin America, users may travel from relatively less developed countries such as Bolivia, Peru and Ecuador for specialized services in Chile, which has more developed medical facilities. MERCOSUR, the regional trade agreement in South America between Argentina, Brazil, Uruguay and Paraguay, attempts to facilitate cross-border mobility of consumers by integrating health insurance systems, and creating links between health cooperatives in border areas.

Migration of personnel

Canada and the U.S. recruit nurses from Argentina, Chile, Colombia, Jamaica, Mexico, and Trinidad and Tobago. (Canada both recruits and "exports" nurses.) In 1996, 110,000 nurses working in the U.S. came from abroad. The U.S. also employs about 150,000 foreign doctors, mostly from Asian countries; with its uncontrolled health care system, the U.S. had a shortage in 2000 of 35,000 general practitioners, and a surplus of 115,000 specialists.

Migration of clinicians raises several important questions, including international agreement on standards for professional training and practice, adequate availability of trained clinicians and service providers in countries that "import" and "export" such workers, and assurance of fair working conditions.[32] These questions call for international conferences and standard-setting. But they are not appropriately codified in a trade agreement, nor can licensing standards be viewed primarily as barriers to trade.

The U.S. has advocated harmonizing professional standards under NAFTA, efforts resisted by Canada and Mexico. Requirements for permanent residency have been removed under that agreement. Mexico provides national licenses for MDs, while in the US and Canada states and provinces play that role, with active participation by professional associations. These different systems complicate integration, and necessitate careful consideration.

Justification C. Private health insurance can reduce public expenditures for health, making systems more efficient.

Response C:

In the 1990s international financial institutions such as the World Bank and International Monetary Fund encouraged developing countries to privatize health care, leaving only the poorest population in the public sector. Intermittent recessions reinforced this trend. Funding for health care ranges from about 2% of GDP in Antigua to over 9% in Canada and about 13% in the U.S., per Table 1.

Affiliates of U.S. health insurance companies established significant presence in Latin America starting in the mid-1990s. The resulting privatization of formerly public health systems has diverted funds and other resources from critical health needs to administration.[33] **Co-payments and other mechanisms have driven up the cost of care, increasing family spending on health care, and presenting barriers to access.** Increasing demand is straining public hospitals and clinics. The budget for the Argentinean agency that is comparable to the U.S. Center for Disease Control and Prevention, responsible for identifying hazards including bioterrorism, has been cut by 85%.

Canada has declined to open its health insurance sector to FDI through the GATS process, which requires countries to agree to liberalization in each sector. The FTAA has no such process. If health care services are included in the FTAA, Canada will not have the ability to exclude private health insurance companies from competing in its national health insurance system. Unlike the U.S., Canada currently provides universal coverage for health care.

The U.S. faces persistent high rates of uninsured residents in its market-based system of private insurance. The uninsured have poorer access to health care and worse health outcomes than those with insurance. Health insurance rates continue to rise.

The ability of state and national governments to control payments for prescription drugs and other health services could be severely proscribed by the investment provisions of the FTAA, which would subject such actions to legal challenge, financial penalties and retaliatory trade sanctions.

Justification D. Privatization of water can expand access to water in developing countries, and control costs in developed countries.

Response D:
The World Health Organization has declared that: "**No single intervention has greater overall impact upon national development and public health than does the provision of safe drinking water and proper sanitation."**[34] International accords regard water as a public good, and increasing access to water as a high priority. Water is considered a good under NAFTA, while water collection and delivery are considered services. Water privatization has been adopted in parts of the U.S., a relatively new phenomenon, and promoted in the developing world by international financial institutions.

The U.S. Senate considered legislation in 2002 that would have required local governments to consider privatizing their water systems.

NAFTA water lawsuit Sun Belt Water, Inc., of Santa Barbara, sued the government of Canada for $14 billion because British Columbia banned the export of bulk water. The claim was based on future lost profits the company could have realized, had it not been precluded from entering the water-export business in that province. If NAFTA investment provisions are adopted by FTAA, federal, state, and provincial governments through the Americas would be similarly prohibited from imposing performance requirements on foreign investments.

California and other parts of the U.S. face similar proposals by private companies seeking to export water both to and from the state. These new and unproven technologies could have ecological consequences that bear serious consideration by accountable public officials. Public scrutiny and regulatory protection of the population could be effectively chilled by the threat of lawsuits and penalties, to the detriment of the public's health.

Access to public water in the Americas **Over 85% of U.S. water systems are publicly owned and operated.** These systems face increased costs to maintain safe operations, and diminishing water supplies. Increasing numbers of beaches in the U.S. have closed during the summer in response to reports of e. coli infections in the water, frequently due to contamination from sewage. It is estimated that the private provision of clean and safe water could generate $800 billion to $1 trillion a year, and private corporations have increasingly sought a role. The results have often been disastrous for affordability and service.

The situation in Latin America is considerably more severe. The WHO reports that less than half the population in rural areas have access to safe water in thirteen countries, including Argentina, Bolivia, Ecuador, El Salvador, Haiti, Honduras and Nicaragua, and that in most countries more than a third lack access. The well-known revolt against a 200% increase in rates charged by the Bechtel Corporation in Cochabamba, Bolivia, has been replicated, more quietly, in numerous locations. Bechtel is suing Bolivia for $25 million for loss of their contract. The legal action is being heard by the International Centre for the Settlement of Investment Disputes, an international tribunal housed at the World Bank.

While privatization may promise savings and efficiency, such promises have proven illusory, with increases in spending for water borne by citizens through higher bills. Private operators must also charge for profit. Private companies have been subject to corruption, neglected maintenance, cuts in the workforce, and price gouging, and have lobbied to lower environmental and water quality regulations that would cut into their profits. It has been difficult for some municipalities to hold companies accountable in the face of long-term contracts, or to cancel those contracts. And after years of relying on a private contractor, public systems may lose the capacity and skilled workforce required to resume operation of their system.

Privatization of water in the Americas While not every private company has failed in this new market, there have been considerable risks as the following examples reported by Public Citizen illustrate:[35]

- In **Lee County, Florida**, in October 2000, county officials decided to return the water and sewer systems to public control, following an audit that revealed serious problems with the private contractor. These problems included: failure to maintain equipment in acceptable working condition; poor handling of hazardous waste; failure to perform preventive maintenance. Following restoration of public control, the county's utility director estimated that the company's failure to properly maintain infrastructure would cost citizens in excess of $8 million.

- In **Atlanta,** significant cost and service efficiencies were predicted from the public-private partnership when maintenance and operation of the water system was contracted out in 1998. Soon after the contracting occurred, the city received complaints of brown drinking water flecked with debris, slow service, and broken fire hydrants. An audit of the contract found: a growing maintenance backlog; company failure in meeting its financial obligations; lower training hours than the contract required; failure to meet contractual timelines to install meters and respond to meter leaks; and difficulties meeting performance targets for pH, turbidity, and phosphate at one of its plants. At the same time, the company had asked for almost $38 million of additional payments through change orders for work that wasn't complete or had not even been started, and sought to increase the contract by $80 million. In January, 2003 the City terminated failed partnership, which was the largest water privatization contract in the U.S. Chris New, the Deputy Water Commissioner in Atlanta said, "My biggest concern is a lot of people have lost confidence in the water itself."[36] Trust in United Water eroded to the point that the city spent $1 million to hire inspectors to verify the company's reports.

    - **Puerto Rico**. Puerto Rico contracted management of its water system in 1995 to a subsidiary of Vivendi now known as Compania de Aguas. In August, 1999, an official report condemned the contract for failing on all grounds, including deficiencies in maintenance, repair, administration, finances, and customer service. Citizens reported receiving bills regularly, but not receiving regular water. The operational deficit reached $241.1 million, requiring emergency funding from the national bank.

    - **Trinidad**. Management of the water system was contracted out to Severn Trent in 1994, with a promise that the water authority would be viable by the end of the contract. The deficit increased to $378.5 million in 1998, and the contract was not renewed.[37]

Alternatively, public sector initiatives have succeeded in the U.S. and Latin America in improving financial viability and service. Aguas Argentinias, for example, used computerized invoicing to update its database, and increased payers to 95%.

SUMMARY

The draft FTAA agreement would define vital human services such as health care and water as tradable commodities, in conflict with an array of international accords that construe access to health care and water as basic rights, as well as being essential to sustainable economic development. The FTAA would facilitate further privatization and deregulation of vital human services, including health care and water. It proposes sweeping new powers for trade tribunals to override public protections if they conflict with the interests of private corporations, and thereby undermines the ability of public bodies to safeguard population health. These provisions assume that a range of public protections are barriers to trade, and therefore warrant elimination. From a public health perspective, the evidence suggests the reverse conclusion: that privatization and deregulation pose barriers to population health, and therefore call for closer scrutiny. These effects are present in both the developed and developing nations of the Americas, although they necessarily differ given imbalances in wealth and power. Efforts to harmonize public health and economic approaches to vital human services should be a priority for trade ministers in concert with the public health community and other advocates in government and in civil society for sustainable economic development. As recommended by the Call for Public Health Accountability in International Trade Agreements, a program for sustainable development must assure that health takes priority over commercial interests.

APPENDIX A: DETAILED COMMENTS ON THE CHAPTER ON SERVICES, SECOND DRAFT OF THE AGREEMENT, DATED NOVEMBER, 2002

CHAPTER ON SERVICES
ARTICLE 1. SCOPE AND SECTORAL COVERAGE

Paragraph 1.1. States that the agreement covers all services in all sectors, including measures affecting access to and use of services required to be offered to the public generally.

Recommendations:
1. Define services to be covered only as those affirmatively listed by nations.
2. Identify a narrow set of commercial services to be included, upon evidence that accelerated trade in those sectors under the terms of this agreement would promote economic growth and equal distribution of wealth among and within nations.
3. Explicitly eliminate public services.

Paragraph 1.4. Identifies the rules and parties subject to the FTAA broadly as any law, regulation, rule, procedure, decision, administrative action, or any other form, taken by any central, regional or local governments and authorities, and non-governmental bodies that exercise regulatory or administrative powers delegated to them by any government authority.

Recommendation: Revise and limit. While this information should be publicly available to civil society in general, the listing for trade purposes suggests that negotiators do not have a clear understanding of which measures actually constitute barriers to trade and should therefore be considered for review. As noted below, it is not clear which entity is expected to bear the burden of reviewing and publishing this exhaustive listing of measures.

Paragraph 1.6. Defines public services to be excluded. This draft adopts a GATS provision exempting public services ("a service supplied in the exercise of governmental authority") from coverage only if it is "supplied neither on a commercial basis, nor in competition with one or more service suppliers." New alternative language grants nations the right to provide law enforcement, correctional services, pension or unemployment insurance or social security services, but would nevertheless apply FTAA rules to these services if they are provided by a foreign service supplier. This language would still transfer away the rights of nations to protect and regulate foreign corporations that provide these vital services, undermining democracy and health.

Recommendations: The agreement should exclude government procurement by a Party or state enterprise, subsidies or grants provided by a Party or a state enterprise, and services or functions of government, including government-supported loans, guarantees, insurance, grants and tax incentives, pensions, income security, social security, child care or protection, air transportation services, law enforcement, and correctional services, and cross-border trade in financial services.

The agreement should specifically list health care services and water systems as excluded services.

Paragraphs 1.7 and 1.8. These paragraphs suggest granting flexibility to developing countries in meeting the commitments of the FTAA, and that "special conditions of treatment shall be given to promote the balanced growth of the Parties and facilitate their increasing participation in trade in services in the Hemisphere." **Recommendation:** Support.

Paragraph 1.9. This section affirms that nations have the right to regulate and to introduce new regulations to achieve domestic policy objectives.

However this language is contradicted in the section on Domestic Regulation, which requires regulations: to be administered in a reasonable, objective, and impartial manner, based on objective and transparent criteria such as competence and the ability to supply the service; are not more burdensome than necessary to ensure the quality of the service; are not in themselves, in the case of licensing procedures, restrictions on the supply of the service; are limited in scope to what is necessary for the attainment of their objectives; avoid abusive monopoly or dominant positions in the market; are aimed at stimulating the use of market mechanisms to achieve regulatory objectives; and do not nullify or impair the obligations under this Chapter or the commitments in nations' schedules. Trade tribunals, not nations themselves, would be assigned to decide whether a regulation meets these criteria.

Recommendation: Assign sovereign nations the unequivocal right to regulate in areas affecting health, including vital human services, protection from harmful substances, and access to affordable medications.

ARTICLE 2: MOST FAVORED NATION TREATMENT; ARTICLE 6: NATIONAL TREATMENT; ARTICLE 7: MARKET ACCESS

Recommendation: Support exceptions stated in the draft for smaller economies and developing countries.

ARTICLE 3. TRANSPARENCY

Requires notifying the all other nations of all relevant pertinent laws, regulations, administrative directives, decisions, resolutions, rulings and measures that pertain to this chapter enacted by federal, central, and state governments, and non-governmental regulatory agencies (3.1 and 3.3). Paragraph 3.5 gives foreign parties the right to comment on proposed measures. **Comment:** These provisions are both a violation of sovereignty and unduly burdensome. It is further unclear which entity would bear the staff and production costs of such an enormous undertaking.

ARTICLE 7: MARKET ACCESS

Paragraph 7.1 Several versions of this section are presented in the draft, indicating ongoing negotiations. The first version presented removes the right of nations to maintain existing measures or adopt new measures, in sectors where market access commitments are undertaken, that would limit: the number of service suppliers, including by an economic needs test; the number of employees in a particular service sector; the types of legal entities or joint ventures; or the total value of foreign capital in individual or aggregate foreign investments. **Comments:** These rules vitiate the ability of nations to regulate vital human services, and possibly to stabilize other areas of national economies.

The second version is an improvement in that it does not include the provisions related to types of legal entities or joint ventures, or the total value of foreign capital. However it still prohibits limits on the number of providers, the total value of services transactions, or the number of employees, including through economic needs tests.

Paragraph 7.3 The second version of this section prohibits requirements that service suppliers maintain a representative office in its territory. This removes the ability of nations to decide when a local presence requirement is a condition for the provision of high quality service.

The fifth version of this section calls affirmatively for developed countries to provide development assistance to smaller economies and developing countries, and improve access to their markets.

ARTICLE 8. DEFINITIONS

Recommendation: Explicitly exclude vital human services from the negotiations, including health care and water. Demonstrate the benefit to economic growth and equitable distribution of wealth for including any other services.

Support proposals exempting central banks, social security/public retirement plans, national security, and other activities by a public entity using financial resources of the government.

SECTION ON OTHER ISSUES RELATED TO THE ABOVE

Domestic Regulation.
As stated above, this section requires regulations to be administered in a reasonable, objective, and impartial manner, based on objective and transparent criteria such as competence and the ability to supply the service; are not more burdensome than necessary to ensure the quality of the service; are not in themselves, in the case of licensing procedures, restrictions on the supply of the service; are limited in scope to what is necessary for the attainment of their objectives; avoid abusive monopoly or dominant positions in the market; are aimed at stimulating the use of market mechanisms to achieve regulatory objectives; and do not nullify or impair the obligations under this Chapter or the commitments in nations' schedules. Trade tribunals, not nations themselves, would be assigned to decide whether a regulation meets these criteria.

Paragraph 6. Professional Qualifications. Comments: Licensing standards were originally included in trade agreements to apply to accountants and to lawyers providing financial services. These rules should not be applied to health care professionals or service workers, as they call for trade tribunals to decide whether professional requirements are unnecessary or burdensome, or restrictions on the supply of a service. The U.S. states vary among themselves in licensing requirements for health care professionals. It is unreasonable to suggest that 34 nations will come to agreement on such standards, or that they should be subjected to the determination of a trade tribunal.

Granting permits/licenses. All parties would be required to eliminate all citizenship or permanent residency requirements. **Comment:** This is already a rule under NAFTA, but has been problematic to implement.

Annex on professional services. The stated purpose is to establish rules for reducing and gradually eliminating barriers to the provision of professional services in the 34 FTAA nations. **Comment:** As noted above, this is a worthwhile objective, but may not be appropriately negotiated in the context of a trade agreement.

General Exceptions. Section b) would permit nations to adopt measures "necessary to protect human, animal or plant life or health." **Recommendation:** It should be added that any central, regional or local government body, or designated non-government authority, shall have the unequivocal right determine the necessity of such measures, rather than a trade tribunal.

Future Liberalization. This section identifies future liberalization as a goal. **Recommendation**: Alternatively, require documented evidence that liberalization has achieved economic growth, equitable distribution of wealth and other measures of population health to be agreed upon, as a condition of further liberalization.

Special and Differential Treatment. Recommendation: Support special treatment for developing and smaller economies, including capacity-building for government and civil society.

Disciplines on Subsidies. This section requires generally that subsidies be necessary, and "least trade restrictive." Subsidies may be permitted for services with social benefits, but it is not clear whether this criterion would prevail over a "least trade restrictive" challenge in an international trade court. **Comment:** Subsidies are an important source of support for social services as well as for emerging economic projects. Footnote 20 refers to particular services where subsidies might be reduced or eliminated, including air and sea transport, tourism, insurance, postal services, construction, research and development, and advertising, and notes that such subsidies may have distorting effects, though the "effect of these policies cannot be accurately assessed."

APPENDIX B: MAJOR ARTICLES OF THE FTAA-FREE TRADE AREA OF THE AMERICAS, SECOND DRAFT AGREEMENT[38]

Transparency
Treatment of the differences in the levels of development and size of economies
Institutional framework
Chapter on Agriculture, including sanitary and phytosanitary measures
Chapter on Government Procurement
Chapter on Investment
Chapter on Tariffs and Non-Tariff Measures
Chapter on Safeguard Measures
Chapter on Origin Regime
Chapter on Customs Procedures
Chapter on Standards and Technical Barriers to Trade
Chapter on Subsidies, Anti-Dumping and Countervailing Measures
Chapter on Dispute Settlement
Services Text, including rules on Domestic Regulation
Intellectual Property Rights Chapter
Chapter on Competition Policy

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[1] WTO Agreements and Public Health – A Joint Study by the WHO and the WTO Secretariat. WHO ISBN 92 4 156214 5, WTO ISBN 92-870-1223-7. Printed by the WTO Secretariat. 2002. A link to the study is available online at: http://www.who.int/mediacentre/releases/who64/en/ The full report is available online at: http://www.who.int/media/homepage/who_wto_e.pdf

[2] C. Iriart, Waitzkin H, Merhy E. International trade agreements, health care systems and social movements in Latin America. Presentation at American Public Health Association, October, 2001.

[3] J. Stiglitz, A Second Chance for Brazil and the IMF, NY Times, Aug. 14, 2002.

[4] Id.

[5] H. Waitzkin, Jasso-Aguilar R, Landwehr A, Mountain, C. Global trade and public health policies: a work in progress. University of New Mexico, Spring 2002. In press.
[6] See S. Russell, L. Gibson. "User fee policies to promote health service access for the poor: a wolf in sheep's clothing?," International Journal of Health Services. 1997, 27:359-79.
[7] S. Rogers, Policy Analyst, California Senate Select Committee on International Trade Policy and State Legislation. Personal communication via email, Aug t 20, 2002.
[8] Macroeconomics and health: Investing in health for economic development. Report of the Commission on Macroeconomics and Health. World Health Organization, November 2001. http://www3.who.int/whosis. Accessed on August 20, 2002.
[9] Id.
[10] International Covenant on Economic, Social, and Cultural Rights (ICESCR), 21 G.A. Res. 2200 (XXI), U.N. GAOR, Supp. (No. 16) 49, U.N. Doc A (6316) 1966.
[11] Stiglitz, supra note.
[12] United Nations Development Programme, Human Development Report 1998. Oxford University Press, Oxford. 1998, p. 29.
[13] UNICEF, Progress of Nations 1998. Oxford University Press, Oxford. 1999, p. 31.
[14] Encuesta Nacional Demográfica y de Salud Familiar 2000, Instituto Nacional de Estadística e Informática, 2001 (National Demographic and Health Survey 2000), p. 14. See also Yamin, AE. Conjurando Inequidades; Vigilancia Social del derecho a la Salud (2d edition) Lima, Peru: CEDAL, 2002.
[15] ENDES 2000, p. 115.
[16] Id, p. 114.
[17] World Bank, Peru: Improving Health Care for the Poor. 1999. p.9. [World Bank Study].
[18] Id. at 10.
[19] Id, at 1.
[20] World Bank Study, p.41.
[21] World Bank Study, p.42.
[22] World Bank Study, p.23.
[23] R. Chanda. Trade in health services. Working Paper No. 63. Commission on Macroeconomics and Health, World Health Organization. June 2001
[24] R. Adlung, Carzaniga A. Health services under the General Agreement on Trade in Services. Bulletin of the World Health Organization, 2001. 79)4):352-364.
[25] T. Rosenberg. The free-trade fix. New York Times Magazine, August 18, 2002. pp 28-33. 50, 74-5.
[26] S. Anderson. Seven years under NAFTA. Institute for Policy Studies, Washington, D.C. http://ips-dc.org/downloads/NAFTA%20at%207.pdf
[27] C. Iriart, Waitzkin H, Merhy E. International trade agreements, health care systems and social movements in Latin America. Presentation at American Public Health Association, October, 2001.
[28] World Health Organization. Dengue and Dengue Haemorrhagic Fever. Fact Sheet No. 117, Revised April 2002. http://www.who.int/inf-fs/en/fact117.html
[29] World Health Organization. Communicable Disease Surveillance and Response. Disease Outbreaks Reported: August 16, 2002; July 12, 2002; July 19, 2002; March 21, 2002; May 8, 2002. http://www.who.int/disease-outbreak-news/n2002.
[30] E.R. Shaffer. The California Health Service Plan, California Health Care Options Project, April 2002. http://www.healthcareoptions.ca.gov/nov01/HCO7%20Shaffer%20California%20Health%20Service%203-31-02.pdf
[31] D. Woodward, N. Drager, R. Beaglehole, D. Lipson. Globalization, global public goods, and health. In: Trade in Health Services: Global, Regional and Country Perspectives. N. Drager and C. Vieira, Eds. Washington, DC: PAHO, 2002. p 6-7.
[32] R. Chanda. Trade in health services. Working Paper No. 63. Commission on Macroeconomics and Health, World Health Organization. June 2001.
[33] C. Iriart et al. Op. Cit.
[34] World Health Organization. Water and Sanitation. Fact Sheet No. 112, November 1996. www.who.int/inffs/en/fact.1112.html,
[35] Public Citizen. http://www.citizen.org/pressroom/release.cfm?ID=883
[36] www.citizen.org/documents/Atlanta-United%20Water.pdf
[37] Hall, D. Water in public hands. Public Services International Research Unit, University of Greenwich, London. June 2001.
[38] Second draft FTAA Agreement. – November 1, 2002. Available online at www.ustr.gov.

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