Trade and Health: Developing a Toolkit for National Assessment

New Delhi, 6-7 March 2007

Report of an Expert Group Meeting

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Opening session

Opening remarks by Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia (read out by Dr Pooonam Khetrapal Singh)

There is an increasing realization that public health may be affected by trade and by the rules set out in international trade agreements, and that trade can affect health in many different ways, both positively and negatively. Some countries in Asia have undertaken extensive analysis of these issues, and have gained experience in putting policies in place to steer the developments in the desired direction. Yet, much of their knowledge is implicit. Meanwhile, other countries struggle to find an entry point for dealing with these often complex and unfamiliar issues.

There are two entry points for conducting a comprehensive national assessment of trade and health. The first entry point is knowledge. Knowledge about trade agreements and how they operate. WHO has worked extensively with countries on this aspect. But the second entry point, which thus far has been neglected, is an analytical framework that can help countries to systematically analyse the implications of trade. This meeting will "kick-start" the development of such a framework or toolkit, and thus ultimately contribute toward a better understanding of the multifaceted relationship between trade and health.

Global perspective (Mrs S. Weber-Mosdorf)

International trade entails risks and challenges for public health, but can also bring significant benefits. Moreover, both the risks and the benefits can play out in the short or long term. It is therefore important to measure the risks and challenges in the light of the benefits.

Traditionally, health ministries have not seen trade as a priority concern, but the World Health Assembly resolution WHA59.26 on international trade and health has changed that. This resolution clearly calls on Member States to ensure that health and trade are balanced and that policies in these areas are coordinated. The resolution also highlights the need for capacity building to increase the

understanding of the health implications of trade and trade agreements. The development of a diagnostic tool to facilitate the comprehensive assessment of trade and health at the national level will therefore be a key component in the implementation of the resolution on international trade and health.

Session 1: Context

1.1 Background and objectives (Dr N. Drager)

Health policies, and thus indirectly health outcomes, are increasingly affected by trade and by the rules set in international trade agreements. Thus, it is important for the health sector to know and understand trade and trade rules. But understanding these rules and agreements is not enough; their implications need to be assessed in order to identify policy issues in a timely manner. Moreover, the implications may vary, depending on the specific national context.

Currently, there is no 'toolkit' that would enable ministries of Trade and Health to comprehensively assess trade and health issues. Such a tool, if it existed, would be useful to obtain a clear overview of opportunities and risks related to trade and health, and could serve as the basis for developing the necessary policy measures. It could, furthermore, be used to prepare input for the trade policy reviews in the World Trade Organization (WTO), and could be the basis for technical assistance requests. The need for a 'toolkit' is highlighted by the fact that very few countries have managed to undertake a comprehensive trade and health analysis.

This meeting was meant to start the process of developing such a toolkit.

The specific objectives of the meeting were:

(1) To initiate the development of a toolkit for undertaking comprehensive national assessments of trade and health;

(2) To identify key issues and prepare specific suggestions for the development of a practical analytical toolkit.

1.2 Introduction of toolkit and workbook (Dr C. Blouin)

The toolkit will be developed in order to:

- Support national governments, in line with the mandate of WHA resolution 59.26, in their effort to develop coherent policies on trade and health and to build capacity to understand implications of trade and trade agreements for health;
- Promote a more systematic approach to analyse cross-border trade and health issues, building on earlier work, e.g. on GATS and policy coherence;
- Help health authorities to structure their requests for capacity building in a context of increasing external resources for trade capacity building, e.g. increased funding from bilateral and multilateral donors, the integrated framework (see 1.3), and aid for trade.

The tool will take the form of a questionnaire with four sections: i) macroeconomic aspects; ii) trade in health goods; iii) trade in food; and iv) trade in health services. It will be structured along the lines of the framework for assessing trade in health services [1]. It is envisaged that the toolkit will help to analyse the situation and draw out the policy concerns.

Its companion piece will be a workbook which is designed to facilitate the use of the tool. The workbook will contain possible solutions, policy options and best practices. It will provide examples of what has worked and what has not in different national situations. It will include:

- Case studies, e.g. on the national process of ensuring coherence between trade and health policies and on flanking policies the countries have put in place;
- References to and examples of existing methodologies e.g. to estimate the cost increase of medicines due to TRIPS plus provisions in bilateral negotiations;
- Decision trees, such as the section “Ten steps before making GATS commitments” [2].

The workbook will also include links and references, including to possible data sources. It will follow the structure of the questionnaire.

1.3 Trade perspective (Mr J. Hancock)

Trade negotiations—once considered the exclusive domain of trade and finance ministries—have recently shown a shift towards enlarged participation of officials and policy-makers from other sectors, including the health sector.

Trade negotiation dynamics display certain inherent features. They are mainly characterized by the interplay of offensive and defensive (commercial) positions and interests of Member States in a

variety of trade sectors. At the national level, these dynamics are sector-sensitive and mainly driven by pressures and politics. In this overall context, the health sector does not enjoy any differential treatment; health is seen as merely another sector to which general negotiating principles apply. It is therefore of utmost importance for ministries of health to get involved in and be part of trade negotiations whose outcomes are likely to affect health.

Among the core competencies of the WTO are the liberalization of international trade, the creation of international rules and the settlement of disputes among Member States. Recently, the WTO has moved towards the adoption of aid for trade practices and schemes. Its main objective is to create favourable conditions for developing countries to take full advantage of the market access possibilities that they already have. Targeted initiatives aim to create and enhance capacity among policy-makers. An Integrated Framework has been created for this purpose. The Integrated Framework includes six international agencies: the WTO, the World Bank, the International Monetary Fund (IMF), the International Trade Centre (ITC), the United Nations Development Programme (UNDP) and the United Nations Conference on Trade and Development (UNCTAD). The WTO's role within the context of the Integrated Framework is one of proactive monitoring aimed at ensuring overall coherence.

While trade and health are obviously two very different sectors, they must be aligned within a country's overarching development strategy. There can be significant synergies, but these synergies and the complementary character of the two sectors are not yet fully understood.

Session 2: Identification of toolkit elements

The identification of toolkit elements was a one of the key objectives of the workshop. Discussions were organized under four headings: i) Macroeconomic aspects; ii) Trade in health goods; iii) Trade in food; and iv) Trade in health services.

2.1 Macroeconomic aspects

2.1.1. Introduction (Mr R. Smith)

Most countries are undertaking trade reforms in order to increase the openness of their economy to international trade; sometimes this is done as a conditional part of structural

adjustment lending (e.g. from IMF and/or the World Bank). Increasing trade liberalization will impact *health*, and *the health sector*.

International trade contributes directly to government income through tariffs on imports. In addition, trade can be an important contributor to economic growth and, hence, can increase the national income, with indirect effects on government revenues. This may benefit health directly through an increased ability to provide health care through public sector revenues, and indirectly through effects on education, household income, consumer values and consumption.

However, this is in the aggregate and over the long term. Tariffs, however, are an important source of government revenue in many developing countries, and especially least-developed countries may not find it easy to replace revenues lost due to tariff reduction by other revenues. Thus, in the short term, for specific countries and/or certain population groups within countries, there are likely to be detrimental effects, resulting in increased inequity.

Key indicators should be identified and monitored in order to track the implementation and impact of trade policy on health and on the health sector. This, in turn, should be used as feedback for policy-makers, inform future trade negotiations and be used to design proactive and responsive health and trade policies.

2.1.2 Discussion and country perspectives

Although greater market openness positively affects growth and thus national income, such a process is likely to develop over a long term. Furthermore, this growth will affect certain groups more *than* others. The distributional effects of economic growth should thus be an integral part of an overall monitoring activity. What is more, increased openness of market economy is a necessary but not sufficient condition to achieve universal well-being.

Is the ratio of trade to GDP a good indicator to measure the degree of openness of an economy?

Can ways be identified in which health positively contributes to trade? If so, this could be a positive factor to use in discussions and negotiations.

Some of those elements of the Human Development Index (HDI) that most directly influence health should be included in the drafting of the toolkit. The actual identification of which elements of the HDI should be included is to be discussed further.

Specific indicators should be included for the purpose of identifying the distributional effects of increased market openness, i.e. how many people receive increased access to services and to which groups do they belong.

The focus should be on the ways in which trade relates to health systems. More specifically, the emphasis should be on interactions between i) financing and trade; and ii) human resources and trade.

Other indicators should address the value of net trade (exports and imports) for concerned countries, the amount of tax revenues, sector average tariffs, public debt-to-GDP ratio, national health account and out-of-pocket financing for health services. The GINI coefficient (which measures the inequality of distribution) should be integrated in the framework. Moreover, it is important to analyse the level of national health budget as an indicator of governments' commitment towards health.

In monitoring and assessing the various indicators, ministries of health should collaborate with their trade and finance counterparts in order to ensure that their respective activities are coherent and sound from the overall, national perspective.

2.2 Trade in health goods

2.2.1 Introduction to trade in health goods (Dr C. Blouin)

Trade in health-related products constitutes about 3% of world trade in goods. International trade in goods increased by 9-14% between 1997 and 2001. International trade in health-related products grew significantly faster, by 55%, in the same period.

When disaggregated by category, pharmaceuticals are the main contributor to trade in health goods (54-56%). This is followed by small devices and equipment (16-19%), supplies and disposables (12%), major equipment (7.5%) and blood and blood-products (5-6%). Smaller amounts are traded of vaccines (1.5%) as well as of contraceptives and condoms (less than 1%) [3].

Industrialized countries mainly export capital-intensive and knowledge-intensive health products, notably pharmaceuticals and large equipment. Exports from developing countries mainly consist of labour-intensive, low-technology goods such as supplies and disposables, and small devices and equipment.

In addition to the volume, origin and destination of health goods that are traded, it will also be important to look at tariffs and at the reliability of the supply.

2.2.2 Trade in pharmaceuticals (Ms K. Timmermans)

Considerable work has been undertaken in the area of trade agreements and their impact on public health and access to medicines, but due to the rapidly evolving environment, a systematic, generally applicable analytical framework has not yet been developed. What follows are some crude, initial thoughts on elements of the framework.

At the level of the overall, national context, key questions relate to whether or not the country is a least-developed country, a WTO member and a signatory to other international or bilateral agreements on trade and/or intellectual property rights (IPR). Secondly, the existence and characteristics of a domestic pharmaceutical industry is important, as well as the relevant tariff levels and industrial policies.

The next important determinant is the legal and regulatory framework, notably, the national IPR law and registration rules. Key questions related to IPR are: i) is there a patent law; ii) is it TRIPS-compliant; iii) does it contain safeguard mechanisms; and iv) does it contain TRIPS-plus provisions. These main questions would have to be broken down further – but a careful assessment should probably be made as to how detailed the framework ought to be and whether a very detailed review might have unexpected side-effects, for example, when this analysis is fed into the WTO trade policy reviews. Moreover, it is not clear whether a fixed set of questions is the most suitable approach for conducting an analysis in this area, since a comprehensive analysis would probably require a very detailed and extensive series of questions. A more limited set of broader questions—intended as a guide for summarizing the situation—may be more useful.

The existence of a drug registration system, its linkage—or not—with the patent system, and the presence of data exclusivity represent the next area to be addressed. Equally important are questions regarding the standards that are applied, and how they affect both trade and health.

Health policies and practices that can magnify or mitigate the impact of trade and IPR-related changes include per capita expenditures on medicine, coverage of (social) health insurance, and the extent to which generics are prescribed and used.

Regarding impact: Attempts have been made to monitor the impact of trade agreements, and particularly the IPR clauses they contain, on prices of medicines. Unfortunately, the results of retrospective studies are very sensitive to the assumptions made, which creates room for subjective interpretation. Meanwhile, prospective studies, such as the ongoing multi-country study by four WHO collaborating centres [4], have the disadvantage that they take a long time. Projections based on economic modeling methods are increasingly being used, and may be the best compromise. Projection-based methodologies are also being experimented with for assessing the implications on health status. But while these immediate effects are important, thought should also be given to monitoring the "TRIPS-promises", namely i) increased foreign direct investment (FDI) in the pharmaceutical sector; ii) increased technology transfer; and iii) increased R&D and innovation.

2.2.3 Discussion and country perspectives

Regulatory standards for medicines are important. They affect the quality, safety and efficacy of medicines on the market, but may also facilitate or impede cross-border trade. Increasingly, regulatory standards are harmonized among countries (e.g. ASEAN, ICH). This facilitates trade, and can improve the quality of available products. Yet there are questions as to whether quality standards are at times set at inappropriate levels and hence become disguised barriers to trade, rather than serving to address legitimate concerns.

Should traditional medicines be addressed in the framework, and if so, how? They are increasingly being commercialized and traded, including across borders. The issues that are relevant for pharmaceuticals equally apply to traditional medicines, but there are

additional concerns, e.g. related to 'bio-piracy' and conservation. Should the framework try to capture these?

In the pharmaceutical sector, should competition be price-based, or based on quality?

2.3 Trade in food

2.3.1 Introduction to trade in foodstuffs (Ms C. Hawkes, by phone)

Liberalization of trade in foodstuffs has two components:

- *Trade in foodstuffs across borders*: The world agricultural trade nearly doubled from 1980 to 2000. Globally, food imports rose by about 60% during the period 1970-2001; however, food imports in developing countries increased much more than those in developed countries (115% vs 45%). Particularly, imports of processed agricultural commodities have been on the rise.
- *Foreign direct investment (FDI) in food production and supply*: FDI increased more than threefold during the period 1990-2004. Most of this is directed towards food processing, but the share of retailing is growing. Nowadays, FDI is generating more sales of processed foods than trade.

A related trend is the growth of transnational food companies; the degree of transnationality of large food companies is higher than that of any other sector. The two largest transnational food companies are supermarket chains.

These trends may affect food availability, food prices and food safety, though their impact is not straightforward. The main health concerns are related to:

- *Undernutrition*: One of the determinants of undernutrition is food security, which in turn is determined by the availability and price of food, at both the national and household levels. Because trade liberalization affects the availability and price of food, it affects food security, but the relationship is very complex and not yet well understood
- *Diet-related chronic diseases*: Trade liberalization has played a role in the "nutrition transition" in developing countries, by increasing the availability and

lowering the cost of certain ingredients and processed foods. Diet, in turn, is a factor in the occurrence of certain chronic diseases.

- *Food-borne diseases*: Concerns about the safety of imported foods in developed countries have led to increases in national food safety regulations. This, however, raised questions as to whether these regulations act as barriers to trade. The WTO's Agreement on Sanitary and Phyto-Sanitary Measures (or SPS Agreement) aims to reduce the likelihood of the latter, while promoting food safety in trade.

2.3.2 Introduction to food safety (Dr J. Schlundt)

Food safety concerns are global. Most countries have seen an increase in food-borne diseases over the last 20 years. The reasons for this are not entirely clear, but a number of contributing factors have been suggested, including new agricultural production systems, a change in age distribution of populations, and increased international trade in food.

The WTO agreement dealing with food safety issues as they pertain to trade is the Agreement on Sanitary and Phyto-Sanitary Measures (or SPS Agreement). The SPS Agreement makes clear that countries should base their food safety standards on scientific evidence and risk assessments. It specifically refers to the FAO/WHO Codex Alimentarius as the international reference with regard to such standards.

Because of this, as well as recent developments with regard to food safety, FAO and WHO have started to define new, risk-based systems for better analysis and management of food safety problems. These risk-based approaches now make their way into all parts of the global food supply chain, including in developing countries, which are likely to become increasingly important agricultural producers. The introduction of a risk-based framework will enable developing countries to learn from mistakes and successes elsewhere, and enable them to "leap forward" into preventative systems. Improving food safety can amount to a win-win situation with improvements in national health status as well as improved export potential.

Investing in food production and food safety systems will allow developing countries to participate more efficiently in world food trade, through better access to the market. This

could result in sustainable economic growth, better food and a fairer world food trade system. It is, however, difficult to assess to which degree food safety systems in developing countries are presently up to the task of scientific risk analysis.

2.3.3 Discussion and country perspectives

It appears that cross-border trade plays only a very limited role in the occurrence of food-borne diseases; more often than not the main source of contamination is domestic. Especially, the widespread belief that food imports from developing countries pose a major risk to food safety in developed countries is not borne out by facts.

In the past, developed countries at times used their standards to keep imports from developing countries at bay. WTO rules make this more difficult. This has led to accusations—largely unjustified—that the SPS Agreement undermines regulations in developed countries.

There are questions as to whether food safety is only an issue of standards, and as to how the SPS Agreement has affected standards and standard setting. Private standards, set by large transnational food companies, play an increasingly important role.

Concerns have been expressed about the limited involvement of developing countries in the setting of standards, such as Codex standards.

Diet, or food, can affect the prevalence of certain chronic diseases; yet there may be a need to distinguish between foodstuff per se, and how it is used. There are, however, questions as to how this can be translated into appropriate policies.

2.4 Trade in health services

2.4.1 Experiences with the GATS framework (Dr S. Siddiqi)

A framework for assessing trade in health services has already been developed by WHO headquarters [1]. It has been used in a number of countries in the WHO Eastern Mediterranean Region, where the Regional Office (EMRO) launched a project for research and capacity building in the area of trade in health services (from 2004-2006).

The project was motivated by a realization that: i) there is a lack of understanding and information on the nature and extent of trade in health services, and the risks and opportunities it may entail; and ii) research capacity in this area is limited. The project was conceived to address this, while simultaneously raising "trade in health services" on the policy agenda.

The key components of the methodological framework are:

- Review the overall macroeconomic and trade environment and the domestic health system as a contextual basis for assessment of trade in health services;
- Estimate, as much as possible, the direction, volume and value of trade in health services for the four modes of supply under GATS;
- Analyse the level of country commitments for providing and/or seeking market access to health services;
- Assess the challenges and opportunities posed by liberalization of trade on the provision of health services and identify options for national policy-makers.

The framework provides a systematic, structured approach to collecting data on most of the relevant aspects of trade in health services. This helped improve the quality of the country studies. Furthermore, the framework facilitates comparison across countries, especially when they are at a similar level of socioeconomic development, and provides a basis for improving policy coherence among trade and health professionals.

Challenges encountered were a lack of data and limited institutional capacity, which meant that few researchers were able to independently use the framework. An important limitation of the framework is that it is not designed to assess the impact of trade liberalization on the health care system.

2.4.2 Thailand's experience (Dr J. Arunanondchai and Ms C. Akaleephan)

The area of health services trade that is most important for Thailand is the provision of health services to foreigners (mode 2). Thailand plays an important role as provider (exporter) of health services under this mode. Since the late 1980s, the Thai government has

promoted trade in health services, by providing tax incentives for investment in private business including private hospitals. This policy, coupled with the economic boom during 1989–1996, has resulted in the mushrooming of urban private hospitals. Between 1987 and 1997, nearly 200 hospitals were established using this tax incentive. However, the share of FDI was very small; it was mainly domestic investment. During the 1997 economic crisis, investment in private hospitals reduced dramatically. Some private hospitals then introduced new marketing strategies; they offered packaged services and specifically targeted foreign patients. Their relatively competitive price, the high quality of services and the excellent hospitality have contributed to a rapid influx of foreign patients.

Realizing the potential for the provision of health services to foreign patients, in early 2003 the government actively started to promote Thailand as a centre of excellent health care. It aimed to recieve 850 000 foreign patients in 2004. An income of US$ 500 million was expected for 2004; it is projected that this could rise to US$1 billion by 2008.

Meanwhile, health services trade in the other modes is relatively small, though some Thai hospitals have started to invest in hospitals in neighbouring countries. Thailand allows for temporary migration of health professionals (mode 4), yet both the influx and outflow are limited by language barriers.

In addition to well-known concerns about access, quality and equity, key policy concerns relate to how international trade in health services can counter or exacerbate pre-existing policy challenges, such as (internal) brain drain and uneven distribution of health personnel and facilities between rural and urban areas. Policies that mitigate a potential negative impact—notably policies to protect those who lose out—are of crucial importance. In the case of Thailand, multiple measures have been taken, including training more health professionals and the creation and expansion of a universal health insurance system.

2.4.3 Discussion and country perspectives

Stakeholder engagement is one of the important factors for ensuring policy coherence. The number of stakeholders can be significant, and they need to be engaged at

different stages of the negotiations. But since stakeholders have their own interests, their involvement in data collection and analysis is not desirable.

Regarding internal brain drain and a widening salary gap, which is an issue in many countries, it seems there is a risk of development of the private sector at the expense of the public sector. The differences between rural and urban settings should be captured by the framework, including in the light of the likely brain drain from the former to the latter.

With regard to mode 2 (cross-border movement of health consumers), in most countries it is relatively easy to measure the numbers of incoming patients, but it tends to be difficult to get data on nationals seeking treatment abroad. Thus, there is a risk of getting a lopsided view.

Indicators such as nurse-doctor-population ratio, health expenditure per capita and indicators on public health infrastructure and distribution should probably be included in the framework.

Session 3: Preliminary draft of toolkit elements

Based on the preceding discussions, a draft analytical framework was presented and reviewed by the participants (see Annex 2). During the review, questions were raised as to how comprehensive the toolkit and workbook will and should be. On the one hand, they should be as complete and generally applicable as possible. On the other hand, by focusing on the key elements only, these tools would be available faster, which would benefit countries. Thus, there will be a need to find the right balance between these two contradictory requirements.

The participants felt that, despite the number of potential indicators that may be included in the toolkit, its overall structure should be user-friendly. The toolkit should preferably make use of those indicators that are already being monitored by the concerned national ministries. Socially-oriented ministries should collaborate with financially-oriented ministries in order to ensure coherent data monitoring and tracking. In this context it will be important to field-test the toolkit before finalizing it.

Moreover, there is a need to carefully consider the scope of the toolkit. It seems to be designed mainly to prepare a "snapshot". This is useful, but continuous monitoring and evaluation should also be considered.

The participants felt that it may be necessary to add a section on the health system or health system environment, somewhat similar to (and probably immediately after) the section on the macroeconomic and trade environment.

The concept of "flanking policies" to cope with external shocks and/or to otherwise mitigate possible negative effects of trade and trade liberalization may need to be clarified. Examples of such policies, drawing among others on experiences from Thailand, would be particularly useful. But the toolkit and workbook should not in any way be prescriptive; the decisions and policy choices will have to be made entirely at national level.

Finally, questions were raised on the scope of the framework; how should it deal with trade in cosmetics, tobacco, alcohol and products at the interface of drugs and food?

Session 4: The way forward

4.1 Next steps and the way forward

The workshop started off the process of developing the toolkit by identifying policy concerns, questions and gaps, as well as additional elements that may have to be taken into consideration. It also provided ideas and suggestions for the workbook.

Envisaged next steps are:

- Preparation of a draft of each of the main elements of the diagnostic tool and of the appropriate section of the workbook. This will be led by an expert on the topic, in consultation with other experts and users. It will be supported by the WHO secretariat.
- A first draft of the consolidated tool and workbook should be ready by the fourth quarter of 2007.
- This draft will be extensively reviewed by national policy-makers, international experts, partner organizations and other stakeholders.

4.2 Conclusion and closure

The issues that were discussed are complex and multifaceted, but the discussions have helped to enriched the sketchy initial framework. Apart from the numerous technical issues that were raised, the importance of engaging others in this exercise was highlighted. It is important to draw on expertise available in other international organizations, such as the WTO and World Bank, but also to work with other stakeholders such as civil society and the private sector to improve and complete the toolkit.

Attention was also drawn to the fact that countries are at different levels of awareness and even interest in these issues. This should be taken into account during the development of the toolkit.

The participants looked forward to seeing the toolkit, which will be useful to assist Member States in this area. The WHO Regional Offices for South-East Asia and the Western Pacific are ready to contribute to its development by providing inputs and comments.

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Assistant II

Annex 2 Draft analytical framework

Elements	Performance, characteristics, approach, priorities, indicators	What is being traded (imports and exports)	Offensive/ defensive interests	Applicable trade rules and agreements (multilateral, regional and bilateral)	Issues related to ongoing trade negotiations	Health implications *(Implications for health responses and health outcomes)*	Trade implications	Existing regulatory environment	Flanking policies under consideration *(better definition is required)*	Policy concerns	Current capacity and gaps
Macro-economic and trade environment - PRSP priorities	Gini coefficient, HDI, FDI as % of various expenditures, trade as % GDP over time, trends of GDP per capita, % of tax revenues from tariffs. Employment rate, overall and sectoral, tax revenue as % of GDP, inflation, health expenditure as % of GDP (NHA), poverty reduction indicators			All are relevant to macro economics		1.Distribution of trade gains…, 2. Health impact of volatility, 3. Impact of tariff reduction on revenues available for health spending…	National health accounts...	What is the evidence that openness correlates with economic growth?	Safety net eg. health insurance to cover period of trade reform, or in situations with a volatile economy. Maintaining social spending during crisis. Freezing capital in public building infrastructure. Preceding investment in public health infrastructure to ensure rural population access regardless during a decade. Reduce obligatory contributions to health insurance. Reduce VAT.	Which ministry monitors which indicators, coordination needed?	Capacity to interpret indicators in terms of impact on health?

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Domestic health system environment	Health care professional ratios, Access, Regulatory capacity, governance, finance, Population health indicators										
Trade in "bads" and goods with direct health effects SUGGEST CHANGING TO HAZARDOUS	Leading causes of death and disability - data problematic on multi-causality. Epidemiology of consumption, smoker and drinker profiles, Current tax rates - motorbike importation, tobacco, alcohol, consumer response to change in avail. Size of the tobacco industry. Number of fast food premises.	Alcohol, tobacco, weapons, cosmetics, food supplements, toxic products and toxic waste trade (needs specific scope), Cars? Inclusion of products depending on economic consequences of associated morbidity/mortality? Genetically modified products.		FCTC	Environmental considerations	Tobacco imports increase under FTA		Monopolies	Taxes, advertising ban		

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Trade in health goods	R&D spending, Monitoring FDI in the pharmaceutical sector, Monitoring progress on TRIPS promises: FDI increase, R&D innovation, technology transfer, Impact of increased market exclusivity in terms of access.	Supplies and disposals, small devices, major equipment, blood and blood products, vaccines, drugs, contraceptives, traditional medicines, cosmetics (also in previous row) and food supplements, (organs and tissues). Counterfeits	Traditional medicines, protection of local production, cosmetic products, dietary supplement	TRIPS, FTA, GATS, and other goods agreements, TBT	Health negotiator does not want to be the deal-breaker on TRIPS +	Quality, Pricing, Access, Availability and steady supply, Non-regulation of active ingredients in cosmetic products and dietary supplements	Biopiracy and biodiversity. Traditional medicines	National drug regulations. Differentiation between food and drugs, Policies on prescribing and substitution? Policies on prescribing and substitution? Is there a patent law? Is it TRIPS-compliant? Does it contain safeguard mechanisms? TRIPS-plus provisions	Generic prescribing, price controls, procurements, bulk purchasing, registration	Evidence needed for the impact of patents on pricing, Capacity needed to design safeguards and use them.	

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Trade in health services (modes 1, 2, 3 and 4)	Hospital management abroad. Foreign patients being treated. Immigration and emigration of health professionals. Relative competitiveness in particular mode. Health insurance. Education of the health workforce. Value of trade in each mode.	Origin of foreign patients. Mode 2: no evidence	Revenue from foreign patients to service debt.		Desire to enter into trade agreements with source countries for medical visitors. Relative progress by mode and agreement. Domestic regulations may prevent full use of multilateral agreements. Mutual recognition agreements may decrease these barriers.	Mode 2: Dual market structure, severe maldistribution of health resources, internal brain drain, salaries disparities. Mode 3: tiered healthcare system, increased rural/urban disparities Mode 4: brain drain		Mode 1: legislation for confidentiality Mode 2: immigration requirements Mode 3: national legislation on establishing private business Mode 4: immigration/work permit/qualification requirements of recipient countries	Policies to mitigate brain drain.	Open, transparent and inclusive structure, committee on trade in health and social services, include several ministries, professional associations etc.	Difficult to obtain data on volume and value of trade. Need method to study impact of liberalization on health. Teams needed. Plan for analysis. No data on treatment abroad. No systematic collection of relevant data. Unequal agency strength. Research capacity limited. Better networking, training. Public education.

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Trade in Foodstuffs	Mapping position in nutrition transition: Imports of oils and sugars as percentage of total caloric imports. Pricing of vegetable oil. Under-5 mortality. Pricing of staples. Food security. Import and export data. Salt consumption.	NTAE, Processed foods, Cereals, FDI in supermarkets and food processing. Fresh/raw foods.	Agricultural protection	TBT, AOA, GATS, SPS/Codex Alimentarius, Bilateral and regional agreements	Agricultural subsidies. Halal certification.	Undernutrition. Chronic diet-related diseases (have not received sufficient attention). Foodborne disease. Protecting consumers from health hazard and fraud. Promote fair-trade and healthy foods. Prevent dumping of poor quality, and fatty food.	De facto trade barriers caused by misperceptions of food safety, standards as barrier?	Implementation of International health regulations	Labelling content of fat, sugar and protein; lack of international standard on labelling. Grading foods. Sugar tax. Public education about consumption.	National food safety and nutrition council. Food safety policy.	Poor data on burden of foodborne disease. Participation by developing countries in standard-settings.