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INTRODUCTION

Over 150 years ago, increased global commerce underpinned the 19th century pandemics of cholera and other infectious disease. With little available for cure, public health authorities emphasized the quarantine of goods thought to carry the infection. Members of the merchant class resisted this action. Eventually, in Canada and in many European countries, the threat of disease to those wealthier or less infected areas became so great that preventive actions were taken. We face a similar situation today, where the benefits of increased global commerce carry with it risks to health, not only for those living in countries on the margins of, or adversely affected by, increased global trade but also to persons living in more financially secure countries such as Canada, through greater exposure to new or newly resistant diseases and regional insecurities brought on by heightening disease inequalities.

Globalization, health interdependence and infectious disease

Globalization can be described as a process by which nations, businesses and people are becoming more connected and interdependent across the globe "through trade, finance, production and a dense web of international treaties and institutions" (Cameron and Stein 2000, p. S16). Globalization deepens health interdependence. As commerce grows, migration flows increase, international travel is easier and more frequent and global environmental challenges are more pressing, the health of Canadians is increasingly affected by the health of other nations. Transmission of infectious diseases is a cross-border issue of growing importance (Garret, 1996). For instance, tuberculosis (TB) drug resistance is spreading to all countries (WHO, 1997). Only fifty years after the introduction of the first anti-TB drugs, some multiple drug-resistant TB strains are completely resistant to antibiotics. The speed of air travel increases the risks of importing drug-resistant TB into Canada from Russia or Asia. Ten percent of tuberculosis cases in Canada are resistant to at least one drug and one percent are classified as multiple drug resistant TB (Health Canada, 2001, Long, 2000).

Globalization, disease and regional/global security

In addition to their direct impact of the health of Canadians, the re-emergence of infectious diseases can have an impact on global security. Recent research shows that pandemics are not
only important obstacles to economic development (WHO, 2001) but also to political stability (Price-Smith, 2002). This is especially so since many poor countries are also experiencing an "epidemiological transition" to chronic diseases, such as cancer, heart disease and diabetes, largely brought on by the export of Western lifestyles (dietary changes, tobacco products, sedentary work), before having effectively controlled infectious diseases. Increasing levels of disease are linked to a decline in state capacity, and can lead to state failure, national and regional conflict. "State failure frequently produces chaos in affected regions... A example of this is the wide-ranging conflict in Central Africa, where the collapse of governance in Zaire has generated a wide conflict" (Price-Smith, 2002, p.19). In this context, where pandemics and escalating rates of chronic disease can destabilize whole regional systems, preventing disease becomes a security issue for the world policy community that needs to be addressed firmly in Canadian foreign policy.

**Globalization and Canadian values**

The threat of resistant disease and regional conflicts, from which Canada can never fully insulate itself, are reasons enough to examine how Canadian trade and aid policies reduce, or contribute to, disease-producing conditions in other nations, particularly poorer countries in Africa, Asia and Latin America. Our interest in global health, however, is also a reflection of our values. One of the three pillars of Canadian foreign policy is the projection of Canadian values and culture. As the 1995 Canadian foreign policy statement stressed: "Canadians hold deeply that we must pursue our values internationally. They want to promote them for their own sake, but they also understand that our values and rights will not be safeguarded if they are not enshrined throughout the international environment. Canada is not an island: if the rights of people abroad are not protected, Canadians will ultimately feel the effects at home" (p.34). Respect of human rights, for democracy, the rule of law and the environment are key Canadian values highlighted in the statement.

Canadians also hold very strong values toward health. In its research on citizens' values and attitudes toward the Canadian health system, the National Forum on Health underscored a number of these: "There is a broad consensus that the Canadian health care system is a collective accomplishment, a source of pride and a symbol of core Canadian values. The values
of equality, access and compassion are salient” (Ekos Inc and Earnscliffe, 1997). The five principles of the Canada Health Act of public administration, comprehensiveness, universality, portability and accessibility encompass many of these values.

How are these Canadian values being projected at the international level? How are they affected by Canadian trade agreements? What is the Canadian foreign policy toward health? Are there contradictions between the multiplicity of international treaties, covenants and trade agreements to which Canada is signatory, or between our positions and activities from one forum to another?

Objectives and outline of the paper
The objective of this paper is to provide an overview of the different aspects of our foreign policy in health and to evaluate their coherence. The paper is divided in five sections. Four of these examine a different way of viewing health in its international context.

The first section examines health as an internationally recognized human right. It reviews the various international health covenants and declarations to which Canada is a signatory and examines whether and how Canada monitors and enforces its commitments. Health as a human right, we contend, is Canada’s overarching global commitment, with both domestic and international policy implications. The second section discusses health as a means of human and social development. This is embodied in the traditional official development assistance (ODA) wealthier nations give to poorer countries. Until the UN International Conference on Financing for Development in March 2002, ODA levels had been dropping in many donor countries, most precipitously in Canada. This section explores more narrowly the development assistance Canada provides to health projects, and the importance of development assistance in ensuring improvements in global health (reducing disease incidence), health equity (minimizing inequalities in the distribution of disease) and, inter alia, improved economic development and global security. The third section focuses on health as a global public good. This concept extends beyond the traditional approach of development assistance. It recognizes health, and several “intermediary public goods” necessary to promote it (such as the Framework Convention on Tobacco Control, and the Global Fund on HIV/AIDS, Tuberculosis and Malaria) as “global public goods” benefiting all nations and persons participating in their creation, and not merely
those designated by more traditional notions of "donors" and "recipients." This section examines Canada’s engagement with global public good projects, identifying new and important opportunities where these can be enhanced. There are also health implications to international trade agreements, as health services and products are considered as commodities that can be traded. The fourth section reviews Canada's economic interests in this sector, focusing on the Canadian position regarding international intellectual property protection for pharmaceutical products and other health-related trade issues. The fifth section and final section proposes how these four frameworks can inform the development of a coherent Canadian approach to health on the international stage that would protect our interests and reflect our values, and provides several recommendations that derive from this analysis.

A note on methodology
To prepare this report, we reviewed official documents, secondary literature and available statistical data on the various dimensions of Canada’s international relations in health. The secondary literature draws from international and trade law, international public health and international relations. However, there was very little literature on certain aspects of Canadian foreign policy in which we were interested. For instance, there has been no recent academic publication on Canadian development assistance in the health sector. Therefore, we complemented our information with confidential interviews with some key informants and officials, when needed.
Section 1 HEALTH AS A HUMAN RIGHT

The human right to health is embodied in customary and conventional (treaty) law, as well as in a variety of international agreements, declarations and plans of action. In this portion of the paper we concentrate particularly, but not exclusively, on the right to health as treated in the International Covenant on Economic, Social and Cultural Rights to which Canada is a state party. Even before the Universal Declaration of Human Rights was agreed, the founding nations - Canada, among them - of the United Nations reaffirmed "faith in fundamental human rights" (Charter of the United Nations, Second pre-ambular paragraph), agreed to promote human rights and to solve international "economic, social, health, and related problems". (Charter of the United Nations, Article 55, emphasis added) as well as to promote "universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion." Shortly thereafter, in agreeing to the Constitution of the World Health Organization (1946), the participating countries (Canada included) agreed to a number of principles that would apply, in conformity with the UN Charter. The Constitution’s principles seek "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." They defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

The Universal Declaration of Human Rights (1948) in its Article 25 states:
"(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and social services…"
"(2) Motherhood and childhood are entitled to special care and assistance. All Children, whether born in or out of wedlock, shall enjoy the same social protection"

Article 27 of the Declaration states that "(1) Everyone has the right …to share in scientific advancement and its benefits." As well as "(2) Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author" (Universal Declaration of Human Rights as found in Steiner and Alston. 1996. 1156ff).
As Theo Van Boven, former Director of the United Nations Division of Human Rights, stated in 1993, there is a direct connection between what his nation, the Netherlands, considers as the right to health and the founding international human rights documents. "Three aspects of the right to health have been enshrined in international instruments on human rights: the declaration of the right to health as a basic human right; the prescription of standards aimed at meeting the health needs of specific groups of persons; and the prescription of ways and means for implementing the right to health" (Leary, 1994 p. 4).

The right to health is thus cited in treaty or "conventional" law, in customary international law, and a variety of other streams of international agreement. The right to health links a significant and diverse series of international agreements, for example Article 7 of the Convention Against Torture, which states as its aim the protection of "both the dignity and the physical and mental integrity of the individual". The International Covenant on Civil and Political Rights cites the right to avoid "medical or scientific experimentation" without one’s free consent. The Human Rights Committee which monitors the Covenant pointed out in its General Comment No. 6 (1982) that the right to life in the Covenant had been interpreted too narrowly, and should include the obligation to take "all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics." A series of ILO conventions on safety and health elaborates how the rights relate, as does the UN Declaration on the Elimination of Violence Against Women (Leary, 1998).

Richard Elliott cites three key international treaties relevant to the right to health:

- The Convention on the Elimination of All Forms of Racial Discrimination (CERD) in which parties undertake to guarantee everyone’s "right to public health, medical care, social security and social services…"

- The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), in which parties agree to "take all appropriate measures" to ensure, on a basis of equality of men and women "access to health care services, including those related to family planning."
• The Convention on the Rights of the Child (CRC), which includes a series of items related to children with disabilities, special needs, the matter of adequate standard of living, access to facilities to treatment and rehabilitation, etc (Elliott, 2001).

Regional human rights treaties ¹ should also be born in mind, not least the American Declaration of the Rights and Duties of Man, the American Convention on Human Rights and its optional protocol as well as the Charter of the Organization of American States, all of which Canada confronts as a relatively recent member of the latter organization who has not fully taken on the responsibilities of membership. The European human rights system, and the European Social Charter provide examples often worthy of examination in Canadian practice, matters which are from time to time taken into account by Canadian judges (Elliott, 2001. 19-20).

Professor Virginia Leary, a recognized academic commentator on the right to health, has salient advice for those who are pre-occupied with language and legal theory. She states that the right to health "is not an illusory concept". Leary suggests that we work not with a theoretical approach "but with a pragmatic approach observing which acts or failures to act by states or individuals are presently considered as serious attacks on bodily integrity and health and thus violations of human rights" and move on from there (Leary, 1998). The right to health is not least a reference point in Canada’s ongoing participation in the World Health Organization, in which policy and implementation are more central than the niceties of treaty language. The Declaration of the

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¹ Of particular relevance in the context of hemispheric negotiations is the Protocol of San Salvador which in article 10 recognizes the right to health, defines it as a public good and elaborates such steps to ensure it as extension of benefits of health services to all individuals subject to the State’s jurisdiction and universal immunization. The Protocol is attached to the American Convention on Human Rights and both are in force, however, Canada has not ratified either. (See Kinney, 2001 p. 1461) Rights and Democracy and Amnesty International Canada have both studied and worked for the ratification of the Convention.

² The European Social Charter, which came into force in 1965 elaborates a set of 19 rights and corresponding state obligations, among them "the right to protection of health" and "the right to social and medical assistance" as well as "the right to safe and healthy working conditions". States are not bound by all unless they agree, but they must agree to five of seven essential rights including social and medical assistance" as well as five others. The Charter is not enforced by a Court but by periodic reports to a Committee of Independent Experts. A vast body of conclusions and decisions has been built up which have defined and refined the content of the rights guaranteed, including elaboration of the sort of medical and health system that embodies the right to health protection. The European Social Charter enables non-governmental organization – workers and employers groups, for example – to play a formal role in evaluating compliance with social and economic protections.
1978 World Health Conference in Alma Ata, "Health for All" has been a particularly important frame of reference for ongoing development of health policy in a global context.

The international consideration of how best to guarantee and fulfill the right to health took a new step that will facilitate investigation, and, one would hope, advance, over the next three years. On April 22, 2002 the United Nations Commission on Human Rights passed a resolution on the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health." (E.CN.4.Res. 2002.31) which creates the position of Special Rapporteur on this right. The mandate provided for the Special Rapporteur provides a useful international legal context for definition and elaboration of the right: the Universal Declaration (Article 25, para 1), the International Covenant on Economic, Social and Cultural Rights (Article 12), the Convention on the Rights of the Child (Article 24), the Convention on the Elimination of All Forms of Discrimination Against Women (Article 12) as well as the non-discrimination article (5 (e)(iv)) of the International Convention on the Elimination of All Forms of Racial Discrimination. For further reference, the Rapporteur is directed to the General Comment 14 of the Committee on Economic, Social and Cultural Rights, and General Recommendation No. 24 of the Committee on the Elimination of Discrimination against Women. The Rapporteur is to make recommendations on measures to promote and protect the right, a process into which Canada could meaningfully contribute and from which we might gain useful advice in shaping the future of health care in Canada.

**Focus on the Covenant**

Although the right to health is affirmed in a wide variety of international treaties and agreements, the International Covenant on Economic, Social and Cultural Rights in its comprehensiveness has centrality. Canada is a party to the Covenant, reports on its fulfillment of its Covenant obligations, with its performance reviewed by the Covenant Committee on Economic, Social and Cultural Rights. States’ performance as well as the elaboration of the rights in the Covenant are part of the mandate of the International Committee on Economic, Social and Cultural Rights. 

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3 The Committee is composed of eighteen independent experts, elected by the Economic and Social Council for four-year terms and reflecting an equitable geographic distribution. Its current chair is Virginian Baodan Dandan of the Philippines.
Under articles 16 and 17 of the Covenant, "states parties undertake to submit periodic reports to the Committee – within two years of the entry into force of the Covenant for a particular State party, and thereafter once every five years - outlining the legislative, judicial, policy and other measures which they have taken to ensure the enjoyment of the rights contained in the Covenant. States parties are also requested to provide detailed data on the degree to which the rights are implemented and areas where particular difficulties have been faced in this respect." The process of reporting is coordinated by Canadian Heritage (Human Rights Programs). It involves:

- solicitation of reports from ministries
- contributions by the provinces
- submission to the Committee
- initial review by the Committee
- raising of questions by the Committee and opportunity for further submission
- public review by the Committee including opportunity for testimony by non-governmental organizations and questioning of Canadian officials
- concluding observations by the Committee.

The procedures for consideration and follow-up of the evaluations of performance by the Committee, their "concluding observations" is much less clear. In 1998 Canada came under severe Committee criticism. The welfare guarantees (embodied in the Canada Assistance Plan (CAP), which were comparable to the health guarantees, in the Canada Health Act had been rescinded. Canadian governments are now preparing the next Canadian report on compliance, which may give evidence of steps taken in the light of the Committee’s last assessment.

Several articles of the Covenant are of primary importance in elucidating its meaning, including, inter alia, Article 12 on the right to health, Article 2 (1) on progressive realization of Covenant rights, Article 23 on resource use and Articles 25 and 26 on level of economic development and international obligations to assist. General human rights principles regarding non-discrimination apply. The Covenant also takes special account of the needs of groups who have particular needs, above and beyond the general principles of the agreement, including women and children.
Two other dimensions are instrumental in approaching these rights: The obligation on the part of states parties to respect, protect and fulfill the rights in question and the principle of the interdependence of human rights, underlined by the Declaration of the Vienna World Conference on Human Rights (1993).

**The International Covenant on Economic, Social and Cultural Rights (ICESCR) Article 12**

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
   (a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
   (b) the improvement of all aspects of environmental and industrial hygiene;
   (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
   (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness

   (from Steiner and Alston 1996, p. 1178)

**Interpretation**

While not particularly well known publicly and slow to permeate domestic jurisprudence (Claydon, as early as 1986 notes, however, the trend to increasing citation of international human rights agreements by Canadian judges), important work by the Convenant Committee, by jurists and by other interested groups has been done on the scope, content and the interpretation of the Covenant.

- The Limburg Principles (1986)
- The Committee hearing on the right to health (1993)

Most immediately relevant is the Covenant Committee’s General Comment 14 on the Right to Health published in 2000.

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4 The Committee on Economic, Social and Cultural Rights has undertaken to elucidate the content of the right to health on at least two important occasions. In 1993 it organized a hearing on the Right to Health, inviting the WHO and other interested organizations and individuals to present their views. (see Rene-Jean Dupuy, The Right to Health as a Human Right, Workshop, The Hague Academy of International Law and the United Nations University (Sijthoff & Noordhoff, Alphen an den Rijn, the Netherlands, 1993) In 2000 the Committee published General Comment 14 on the right to health, the most comprehensive statement on the right to date. (United Nations, Committee on Economic, Social and Cultural Rights, U.N. ESCOR, 22d Sess., The Right to the Highest Attainable Standard of Health, U.N. Doc. E/C, Dec. 4, 2000, ICESR General Comment 14 (2000)).
The steps to be undertaken are listed initially in Article 12, paragraph two. Early advice to the Committee included the importance of taking into consideration the specific goals and indicators developed by the WHO, including the fundamental importance of primary health care and the goal of health for all, agreed at the World Health Conference in the Alma Ata Declaration of 1978. The Committee did not adopt the full definition of health in the preamble to the WHO constitution but declared that the right "is not confined to the right to health care."

The Committee’s General Comment 14 explores the normative content of Article 12, and then examines "special topics of broad application" including: non-discrimination and equal treatment, gender perspective, women and the right to health, children and adolescents, older persons, persons with disabilities, indigenous peoples, etc. It explains the implications of "progressive realization" and outlines the specific legal obligations of states parties. It notes as well that states parties have international obligations, for example, to respect the enjoyment of the right to health in other countries and "to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law" (General Comment 14.1 2000. para. 39).

The Committee’s General Comment 14, recognizes that the right to health does not imply the "right to be healthy". It also notes that the right contains both freedoms (such as the right to control one’s body) and entitlements (such as the right to a system of health protection which provides equality of access.) It also declares that health is a human right "indispensable for the exercise of other human rights." The Comment notes that the right extends to "underlying determinants of health", such items as sanitation and potable water, nutrition, access to health-related education and information. Health care systems must have institutional characteristics such as availability, accessibility, acceptability and quality of health care services and facilities. The Comment defines these characteristics. The Comment reaffirms a number of core obligations on states parties (see outline Table 1).
### Table 1

**Obligations Regarding the Human Right to Health**  
**Core Obligations Established in**  
**Prior International Human Rights Instruments**

To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups:

To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

To ensure equitable distribution of all health facilities, goods and services;

To adopt and implement a national public health strategy and plan of action, the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

**Obligations of Comparable Priority:**

To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

To provide immunization against the major infectious diseases occurring in the community;

To take measures to prevent, treat and control epidemic and endemic diseases;

To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

To provide appropriate training for health personnel, including education on health and human rights

From Figure 5 in Kinney, 2001. p. 1469
Comment 14 also deals with violations of the right to health. In the area of resource application it should apply all available resources or have the burden of justifying that "every effort has nevertheless been made to use all available resources at its disposal". This language is not as vague as it might seem. In 1998 Canada came under clear criticism by the Covenant Committee for the prevalence of food banks, given what the Committee held to be its relative level of wealth and development.

States parties are also responsible to ensure that all within their jurisdiction are safeguarded against infringements of their rights by third parties. The Maastricht guidelines establish that corporate actors are among those third parties. States are also in violation if their actions or laws contravene the standards of Article 12 and "are likely to result in bodily harm, unnecessary morbidity and preventable mortality." The implication is that the Government of Ontario was in violation given the results of the Walkerton inquiry. At a more universal level, questions of the interpretation of international law, of treaties like the Covenant, customary matters like the acceptance of the Universal Declaration, general principles and legal doctrine are all matters under the jurisdiction of the International Court of Justice. On a few occasions, issues relating to the implementation of the Covenant have been taken to the Court (Leary, 1994, Elliott, 2001).

**How is a state to know?**

The issue of "realistic" implementation and enforcement of the right to health is a matter of considerable debate. States can and do cite a variety of impediments and limitations. Demands are variable, culture diverse and resources fluctuate. There have been and are a number of initiatives in the direction of establishing more specific outcome measures regarding state compliance with core obligations. Kate Raworth of the United Nations Development Programme, speaking in Canada in September, 2001, noted that "the way forward to increasing accountability is to develop a framework for selecting quantitative indicators that assess the extent to which a state is meeting its obligations under human rights law" (Raworth, 2001). She recognizes that while obligations are universal, the indicators may vary from context to context. She also admits that establishment of indicators is inevitably complex, but says this simply "reflects the fact that human rights often involve the most basic dilemmas of human society."
The work is essential and involves not only governments, Commissions of human rights, but non-governmental organizations as well.

Prof. Kinney advocates establishment of outcome measures, including a variety of statistical tools. The *World Health Report 2000*, presents a number of performance measures including the creation of a comparative international reporting system. Unfortunately the 2000 *Report* has some serious methodological limitations which tend to distort some of its findings (Navarro, Nov. 4, 2000; Almeida, May 26, 2001), but clearer international comparable indicators in a variety of areas would be helpful. Kinney also suggests the use of violation of recognized civil rights (i.e., discrimination in access to health care facilities) to highlight the right to health or the violation thereof.

**Reporting mechanisms**

Reporting mechanisms are one of the few levers by which the fulfillment of international human rights commitments can be encouraged if not strictly enforced. The reporting system can be adapted to deal with new challenges. For example in its resolution 2001/21 the UN Sub-Commission on Human Rights, in dealing with intellectual property, the Doha WTO Ministerial and the issue of access to medicines, suggested that the Committee on Economic, Social and Cultural Rights explore, "in the course of reviewing States parties’ reports, the implications of the TRIPS Agreement for the realization of economic, social and cultural rights. (ECOSOC, 16 August, 2001). Canada, which is currently preparing for its next review by the Committee in 2003, should take this into account. With regard to the issue of access to medicines the Human Rights Commission in its resolution 2001/33 requested the Secretary-General to solicit comments from Governments and others on the steps they were taking to promote and implement this Commission resolution. (UNHCHR, 2001/33). To date we have not been able to confirm any Canadian response to these latter resolutions.

International updating and monitoring of such current health rights issues continues. The Commission on Human Rights resolution (2002/32) of April 22, 2002 on Access to medication in the context of pandemics such as HIV/AIDS continues the invitation to the Committee on Economic, Social and Cultural Rights, to states and to the Secretary-General of the UN to deal
with the issue of access to medicines. Additional guidance on the issue of intellectual property and human rights is being prepared by the Committee on Economic, Social and Cultural Rights. Further, the Commission resolution (2002) mandating a Special Rapporteur on the Right to Health (see below) represents increased attention to the observance of the right to health globally. The reporting practice under the Covenant on Economic, Social and Cultural Rights is only one of a number which in some way relate to the right to health, constituent or related elements thereof.

**A specific challenge**

Canada is a party to a number of international human rights agreements to which its nearest neighbour is not. In 1953, the US announced to the Commission on Human Rights that it had no intention of ever ratifying any international treaty on human rights, arguing that its domestic levels of protection were superior to those offered through the UN. This left the international human rights and of their enforcement weakened. In 1989 the US ratified the Genocide Convention, and in 1992, the Covenant on Civil and Political Rights (Evans, p. 97 ff). In 1994 the US ratified the Convention against Torture and the International Convention on the Elimination of All Forms of Racial Discrimination Convention.

The Covenant on Economic, Social and Cultural Rights is one of an extensive list of international human rights agreements not (yet) ratified by the U.S.. While the US signed both the Convention on the Elimination of All Forms of Discrimination against Women (1979) and the Convention on the Rights of the Child (1989), it has yet to ratify either. The recent US withdrawal of its signature from the International Criminal Court agreement represents "a la carte multilateralism" at best. Neither the U.S. nor Canada has yet ratified the American Convention on Human Rights or the San Salvador Protocol, although active discussion, including a review in 2002 by the Senate Committee on Human Rights, continues in Canada.

With regard to the Covenant on Economic, Social and Cultural Rights, Canada must account for its fulfilment of its obligations, the US does not. As Philip Alston, former Chair of the Committee on Economic, Social and Cultural rights has commented, Americans, in particular cannot "get past conceptual issues to reach the vital practical ones" (Leary, 1998). For a
Canadian government interested in the achievement of universal respect for human rights this might suggest foreign policy priorities, for example, encouragement and pressure on the allied government to ratify the agreements and interest and exchange with those extensive professional and expert groups in the United States who share the same objective.

At the same time, the failure of the US to fully take on these multilateral standards and obligations does not remove it entirely from the right to health. The US was a signatory to the Universal Declaration, which has the force of international customary law, and the US was a party to and ratified the Constitution of the WHO. It also ratified the Covenant for Civil and Political Rights, which given the Vienna Declaration regarding the inter-dependence of rights, implies some measure of recognition of economic, social and political rights. Further, at least 21 U.S. states have references to social assistance or public health in their constitutions.

As US Prof. Eleanor D. Kinney points out, customary international law, "imposes obligations on states, including the United States, that have not ratified the treaties" (Kinney, 2001, 1457). Canadian legal analyst, Christine Elwell, while noting that the US "remains the only major industrialized democracy that has not ratified" the Covenant on Economic and Cultural Rights, notes "nothing precludes treaty rules from becoming customary international law and thus binding on non-parties" (Elwell, 1995, 62). For Canada, however, particularly in the face of pressures for bilateral harmonization of policies in a variety of sectors, the potential of conflict with its multilateral obligations, in human rights as in a number of other fields, must be dealt with.

A clear affirmation of Canada’s recognition of the right to health is the obvious starting place for health policy that is resilient in the face of these pressures. Given its previous extensive history in progressively realizing that right for all residents on a non-discriminatory basis, Canada has a remarkable opportunity to further elaborate and embody the right in further public policy. As for inevitable pressure from our great neighbour, the fundamental principle to be applied would be that where the international standard is better than the harmonization suggested, the international standard should prevail. Further, the clear continuing commitment to multilateralism as a principle in Canadian foreign policy should be sustained.
Human rights, international law and Canada’s obligations

"Human rights and fundamental freedoms are the birthright of all human beings; their protection and promotion is the first responsibility of Governments."
From para. 1 of the Vienna Declaration and Programme of Action.

Some 109 countries recognize a right to health in some form in their constitution. While Canada’s constitution is not so explicit, "basic obligations to respect economic and social rights may be implied from the language of constitutions that do not expressly guarantee social and economic rights but contain broad protections of life or security of the person. In Canada, for example, the Supreme Court of Canada has expressly left open the possibility that the Charter’s guarantee of life, liberty and security of person might be used to prevent the government from depriving an individual of ‘those economic rights fundamental to human life or survival’" (Ministry of the Attorney General, 1991).

The Universal Declaration
Canada’s view of its human rights obligations has been stated as follows:
"It is the view of the Canadian Government that the observance of human rights is obligatory under international law. The Canadian Government views the Universal Declaration of Human Rights as a valid interpretation and elaboration of the references to human rights and fundamental freedoms in the Charter of the United Nations. Consequently, the obligation on states to observe the human rights and fundamental freedoms enunciated in the Declaration derives from their adherence to the Charter of the United Nations" (Rights & Democracy, 1999).

As a Canadian Cabinet member put it in 1995, "The UN Charter obliges all members to promote universal respect for human rights and Canada regards the principles of the Universal Declaration of Human Rights as entrenched in customary international law binding on all governments" (The Hon. Christine Stewart as quoted in Rights & Democracy, 1999). As Rights and Democracy has pointed out, Article 103 of the UN Charter establishes that the Charter takes precedence over other international agreements, and note explicitly "international human rights and labor norms guide the interpretation of international trade and investment obligations where state parties hold common commitments under jus cogens, customary law or treaty; to the extent
that these norms are interpreted as within the scope of obligations under the UN Charter, its Article 103 pre-empts other treaty obligations including those under GATT agreements, in the event of a conflict.\(^5\)

The Covenant on Economic, Social and Cultural Rights

While the Universal Declaration is not, per se, a legally binding instrument, the Covenant on Economic, Social and Cultural Rights is a treaty, and as such is both a part of international law and legally enforceable under the national law of a number of countries. Canada has ratified the Covenant. The Covenant binds its parties to achieve the full realization of the rights enumerated by all appropriate means, recognizing that such achievement depends on the principle of "progressive realization", i.e., that the state realize these rights "to the maximum of its available resources." (Article 2 (1)) The level of achievement of the right must be "adequate" (Article 11 (1)), a term which has definite legal content (Matas, 1995).

In 1998, the Committee on Economic, Social and Cultural Rights adopted a General Comment (No. 9) dealing with the domestic application of the rights enumerated. It held that states are bound to provide for legal remedies to violation of the rights, through consistent interpretation of domestic law, and through adoption of legislative measures to provide remedies for violations. Three basic principles were outlined for compliance:

- The means chosen by the state must be adequate to give effect to the right
- Protection for economic, social and cultural rights should be comparable to protection provided for civil and political rights.
- Direct incorporation of economic, social and cultural rights into domestic law is desirable, if not absolutely required (Jackman/Porter, 1999, p. 3).

A number of Canadian experts and human rights groups have argued that the upcoming revision of the Canadian Human Rights Act is an appropriate place to bring Canada into compliance with these principles. Further they have suggested that the Canadian Human Rights Commission be

\(^5\) In their technical brief to the Standing Committee on Foreign Affairs and International Trade (Rights & Democracy, 1999) they refer to work by Janelle Diller of the Georgetown University Law Center and David Levy of the International Law Institute. See also the Vienna Convention on the Law of Treaties, concluded in 1969 which entered into force in 1980. (Vienna 1980).
given a specific mandate to evaluate and report on Canada’s fulfillment of its international rights obligations. While compliance with the Covenant on Economic, Social and Cultural Rights is central to the realization of the right to health in Canada, it is clear that compliance with other Covenants, including that on Civil and Political Rights, is relevant as well. The Human Rights Committee, for example, noted in its 1999 review of Canada’s compliance with the latter, "underlined the discriminatory effects of poverty and social program cuts in Canada" as well as the lack of adequate access to remedies for human rights violations (Jackman/Porter 1999, p. 1). The non-discrimination principles was applied nationally when the Federal Court of Canada found that the Charter’s equality provisions required provision of paternity benefits to men as well as to maternity benefits to women.

The connection between the international treaty and Canadian law is not as clear as it may be in countries which include reference to such international obligations in their constitutions. The Canada Health Act R.S.C. 1984 has created "a perception in Canada of a ‘right’ to health care services (or at least the basic right of ‘reasonable access’ to health care services" (Capen, 1996.p. 15). The wording of Section 3 of the CHA in setting out the primary objective of Canada’s health care policy, could be read to embody at the domestic level the right to health as expressed in international treaties:

"It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers. The underlying philosophy is that all residents are entitled to universally accessible personal health services, with medically necessary services to be provided on the basis of need, not on ability to pay" (Capen, 1996 p.13).

Further, as the Canadian Bar Association Task Force on Health Care noted, in their report *What’s Law Got To Do With It?* (1994), "Canada’s adherence to these international instruments demonstrates support for state responsibility for the provision of basic social security, including health care." Further they cite the Supreme Court which stated "[w]here the text of the domestic law lends itself to it, one should also strive to expound an interpretation which is consonant with the relevant international obligations" (CBA, 1994, p. 24).
However, the CBA Task Force states that there is no explicit right to health care under the Charter, the Charlottetown negotiations did not result in an agreement to include one and the courts have been "very reluctant" to impose obligations on government to act for positive rights. Nevertheless, Section 7 of the Charter protects three distinct rights: the right to life, to liberty and to the security of the person. In considering the possibilities of legal action under this part of the Charter, the Task Force concluded that "although there is no right to health care under the Charter, it does provide procedural protection for the equitable distribution of health care benefits" (CBA, 1994, p. 59).

While the right is not explicit, the general expectation among Canadians, the Task Force noted, that they have such a right has created a significant gap. Further, there is an "express or implied right to health insurance under provincial health insurance acts", but these lack guarantees of the content of the health insurance (as experienced, for example, in the de-listing of services) and thus do not fully guarantee a right to health care. Therefore, the Task Force recommended that "those provinces which do not have a legislated right to health care should define and legislate such a right" (CBA, 1994, p. 40).

Recently, the Human Rights Committee of the Canadian Senate reviewed how Canada was implementing its international human rights obligations (Senate, Promises, Dec. 2001). They noted that it was insufficient for Canada to rely solely on the gradual integration of these obligations into decisions by Canada’s courts. "International human rights obligations", they state "are no less binding upon us than our domestic guarantees. Obviously international commitments cannot be enforced to the same extent without converting them into domestic law. But this is precisely the problem. Signature and ratification of international human rights treaties carries with it an obligation to submit to international scrutiny. But, in addition, we have an obligation to effectively implement the rights with Canada, in a manner that goes beyond mere reliance on the Charter. International human rights are not simply promises we make to other countries or to the international community as a whole. They are rights that all people have and that we have pledged to respect and implement in our country."
The explicit inclusion of the right federally is an appropriate first step in the renewal of the health care system in Canada. Such an inclusion would be best lodged in the Charter, but lacking that could be included in a renewed Canada Health Act, in a revised Canadian Human Rights Act and in a "charter" of health commitments which the Federal and Provincial governments might be encouraged to agree. The Canadian government has, in its reporting of compliance with its obligations under the Covenant, told the Committee on Economic, Social and Cultural Rights that the Canada Health Act is one of the means by which it fulfills its obligations to the right to health. It could thus be argued that there is a rights link in custom and practice if not explicitly in the constitution.

In defending its termination of the welfare guarantees of the Canada Assistance Plan (CAP) before the Committee on Economic, Social and Cultural Rights, the Canadian government ran into considerable difficulty, in part, because it had in previous reviews identified CAP as one of the ways in which it fulfilled its rights obligations. The government cited federal/provincial division of jurisdiction and the Social Union, but was largely unable to explain how the abandonment of CAP was not a regressive step and in violation of its obligations. In the welfare field, pending a public and participatory review of the Social Union, it would not appear that this vulnerability on Canada’s part has been repaired.

Actions, whether legislative, regulatory or judicial which further integrate Canada’s obligations to respect, protect and fulfill the right to health under the Covenant (as well as the UN Charter/UDHR) can contribute to removing this gap. An amendment to the Charter of Rights and Freedoms to bring the right to health along with other Covenant rights fully into the Constitution may be the most secure, if more difficult, option.

**Human rights and trade agreements**

The new generation of trade and investment agreements has provoked, albeit belatedly, fresh consideration of the relationship between Canada’s existing human rights obligations and new economic agreements.\(^6\) Recently, the Canadian Parliament's Standing Committee for Foreign

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\(^6\) A few Canadians - some church bodies, the ICHRDD, the Human Rights Project of Common Frontiers - raised issues of the human rights implications of agreements like the FTA, the NAFTA and the proposed MAI beginning in the mid-1980s. Official recognition of the problems and international consideration of the implications was late to arrive
Affairs and International Trade (SCFAIT) published its report *Balance, Transparency and Engagement after the Quebec Summit (SCFAIT, 2001)*. The Committee recognized the issue of how best Canada’s obligations in human rights, labour standards, the environment, etc., might be enforced in relationship to trade agreements and asked the government to report by April 2002 (SCFAIT, 2001). The Committee’s action is a somewhat tardy response to the pioneering work of Rights & Democracy, among others, on examining the relationship between the two regimes of agreements (Howse & Matua, 2000). Recently, the Canadian HIV/AIDS Legal Network has taken up work on these essential issues, as they apply to HIV/AIDS (Elliott, 2001). The government response to the SCFAIT’s request to report on this issue is overdue. It would appear that the government’s attention, to date, to the relationship between the trade regimes and human rights commitments has been cursory at best.

United Nations human rights bodies, have, in the last five years, begun to confront the issue of the relationship not only in studies and messages but in resolutions such as the one on access to essential medicines (2001). These initiatives have been due in no small part to the work of scholars and non-governmental organizations, in particular the International NGO Committee on Human Rights in Trade and Investment (INCHRITI), the International Federation of Human Rights (FIDH) and the People’s Decade for Human Rights Education (PDHRE).

Given the panoply of general and specific human right agreements to which Canada is state party, it is fair to ask why the potential implications of trade and investment agreements have seemingly received such cursory attention by those in charge of negotiation and policy "coherence". For many, the issue of the legal relationship between the rights and trade regimes is relatively simple, at least in principle. The use of "rights" language, in the view of Virginia Leary following Ronald Dworkin, implies "a special importance, status, priority". In short "the right ‘trumps’ many other claims or goods" (Leary, 1994 p. 8 , emphasis added). Leary also notes, based on the work of Henry Shue, that there are "basic rights", i.e., those which have a priority because their enjoyment is necessary for the enjoyment of other rights. Health fits the bill.
A further argument derives from the wording of the UN Charter itself, and the direct relationship between the Charter provisions and subsequent human rights agreements, the Universal Declaration and the Covenants. Charter Article 103 notes that in the event of a conflict between Charter obligations and those under any other international agreement, "their obligations under the present Charter shall prevail." Richard Elliott notes that in the Lockerbie case, the International Court of Justice recently reaffirmed this precedence. The International Court of Justice has ruled that action denying fundamental human rights "is a flagrant violation of the purposes and principles of the Charter". Further in the Vienna Declaration the 171 participating states reiterated that the protection and promotion of human rights "is the first responsibility of Governments".

Elliott points out that the obligations not to violate human rights pertain not only to the individual actions of states but to states acting collectively. "As such, the treaties, rules and practices of an inter-State organization such as the WTO must also comply with the overarching human rights requirements of international law (Elliott, 2001 p. 39). He also notes that the 1969 Vienna Convention on the Law of Treaties specifically mentions the principles of "international law embodied in the Charter of the United Nations, such as the principles of…universal respect for, and observance of, human rights and fundamental freedoms for all". After an extensive examination of cases and practices in the WTO which illustrate the intersection of trade and human rights claims, Elliott sums up the matter of access to essential medicines and the application of the TRIPS agreement as follows:

Utilizing the rules of interpretation of the Vienna Convention, he declares "that terms of the TRIPS Agreement must…be interpreted in a fashion that renders States’ obligations regarding the protection of private intellectual property rights compliant with their superseding obligations under the international law of human rights". Any interpretation which precluded countries from taking "reasonable legislative measures to protect public health and comply with their obligations under international customary and conventional human rights law could surely be characterized as "manifestly unreasonable" (Elliott, 2001, p.62).

A more startling argument is made by those who reach beyond human rights agreements to the post-war Genocide Convention, arguing that States are guilty of the equivalent of genocide when they are confronted with the threat or reality of mass death from avoidable causes and refuse to
take action which would save lives. The matter of access to and provision of essential medicines in the case of HIV/AIDS in Africa is case in point (Foster, 2001, 2002).

Canada, as a party to the Covenant on Economic, Social and Cultural Rights has undertaken the obligation of non-retrogression. As the INCHRITI pointed out recently "accordingly, states are not permitted to remove, weaken or withdraw from commitments made and obligation undertaken to implement human rights in their countries. Trade and investment policies and agreements cannot contain provisions which impede the capacity of State Parties to respect, protect, ensure and fulfil human rights… The principles of roll back and standstill being proposed for the WTO can require states under "roll back" to revoke legislation protecting human rights. Furthermore, under "stand still" future national legislative measure to implement human rights could be prevented" (INCRITI, 2001).

The issue of conflict between Canada’s commitments to and obligations regarding the human right to health (and other human rights) and obligations being negotiated under such regimes as the World Trade Organization have only begun to be explored. Given the extensive implications of existing trade and investment agreements for the health of Canadians and the administration and cost of public services (i.e., TRIPs), and the potential implications of agreements currently under consideration (i.e., GATS) for public services and democratic control, the lack of clear enforcement of the legal precedence of human rights law can be understood to be injurious to the present and future rights and health of Canadians. To the extent that this failure extends to Canada’s international policy in such areas as access to essential medicines in the context of pandemics like AIDS it is also a violation of our Covenant obligations.

**Conclusions**

Ambiguities regarding health policy and practice will be reduced and positive guidance for the future of Canada’s health system enhanced if a clear recognition of the right to health becomes the starting or orienting point for renewal. Canada has much to offer and a good deal to gain from a clearer commitment and engagement in international development of the right to health, through the UN system and in its international actions. The existing content and interpretation of the right to health, and the ongoing examination of the relationship of human rights to trade and
investment agreements offer guidance to Canada, which can be applied in implementing our obligations under human rights treaties, observing human rights international customary law and pursuing with resource and energy the policy implications and reporting duties which emerge from the ongoing work of such bodies as the Committee on Economic, Social and Cultural Rights and the Commission on Human Rights.

This avenue of approach implies a legal recognition of the right to health at the highest level attainable, preferably in the Charter. It implies application of human rights commitments in a variety of subsidiary and related elements of health policy. It implies the development of a more effective monitoring and reporting agency within Canadian government structures, whether an enhanced role for the Canadian Human Rights Commission or some other body or process. It implies the human rights assessment of policies, whether domestic or international, which impinge on, potentially enhance or undermine Canada’s human rights obligations. We believe that such an approach would bring coherence and anchor to Canadian health policy and its future development.

Section 2 HEALTH AS MEANS AND GOAL OF DEVELOPMENT

Introduction

This section examines the activities of Canada in development assistance programming related to health. It also highlights key issues regarding development cooperation and health and examines recent policy changes at the World Bank and IMF on the allocation of assistance to developing countries.

For years now, health has been identified by the international community as an essential element of human development. Since 1990, when the United National Development Programme (UNDP) launched its first Human Development Report, life expectancy has been one of the three main variables, with education and income, to measure human development. The World Bank's World Development Report includes improving health, as well as decreasing vulnerability and powerlessness, as a critical aspect of a poverty reduction strategy. More recently, the WHO research report of the Commission on Macroeconomics and Health stressed the importance of
improving health of the poor as a key means to achieve long-term economic growth and poverty reduction (WHO, 2001). The Commission, led by Professor Jeffrey Sachs, calls upon donor countries to increase their assistance to low and middle-income countries for health programming from the current $7 billion annual commitment to $27 billion in 2007 and $38 billion in 2015 (See table A in annex). These funds would cover the difference between the resources developing countries can mobilize and the cost of $34 per person per year to offer a set of essential health interventions to all (essential interventions against infectious diseases and nutritional deficiencies).

This call to action from the WHO provides a detailed evaluation of the financial investments in health needed to reach the Millennium Development Goals. These goals emerged from United Nations conferences and summits held in the 1990s and are focused on poverty reduction: the proportion of people living in extreme poverty should be cut in half by 2015 (see Social Watch, 2002 on monitoring of commitments). These international development goals include health targets aiming at:

1) the reduction by two-thirds of the mortality rates for infants and children younger than five years;
2) the reduction by three-quarters in maternal mortality and access through the primary health-care system to reproductive health services for all; and
3) the end of rising HIV/AIDS prevalence, all by 2015.

Despite the recognition of the impact of health on poverty reduction and economic development, international aid to health still remains low, at approximately 6% of the total bilateral aid granted by OECD members, and 10% of multilateral aid (OECD, 2001, see annex Table B). This lack of strong commitment to Official Development Assistance (ODA) for health programming has to be examined in the context of the declining levels of ODA in the last decade. Indeed, as we can see on Table C of the annex, many OECD countries have reduced their bilateral and multilateral aid budgets. Thus, Canada and the United States have respectively decreased their level of ODA from 0.46% and 0.2% of their respective GDP between 1985-1989 to 0.25% for Canada and 0.1% of the United States in 2000. All donor countries committed themselves to reach a ODA level of 0.7% of GDP, but only five countries have attained it (Denmark, Luxembourg, the
Netherlands, Norway and Sweden). The commitment to the 0.7% target was reiterated at the UN Conference on Financing for Development in Monterrey, Mexico in 2002.

**CIDA and Health**

The Canadian Government has endorsed the international development goals adopted at the UN Millennium Summit in 2000. It has also recognized the status of health as an essential element of human development. Even though its financial commitments in this field are still relatively low, health has been identified as a priority for Canadian development assistance. In recent years, the Canadian International Development Agency (CIDA) has placed greater emphasis on social development priorities, i.e., basic health, nutrition and education, given that these programming activities are considered to have much better returns on investment than others. In 2000, CIDA launched a framework for action on social development to double the funding allocated to these activities in the next five years. This focus on basic human needs follows from the foreign policy framework issued in 1995 by the Government of Canada. A clear mandate was given to CIDA to support poverty reduction in developing countries by concentrating 25% of its ODA to basic human needs (defined as primary health care, family planning, basic education, nutrition, water and sanitation and shelter).

In 1999-2000, CIDA spent CAN$78.8 million on health programming plus $48.5 million on reproductive health and population programs. This represents 6.7% of total Canadian bilateral aid (The North-South Institute, 2001). Moreover, Canada contributed 4% of its multilateral aid to health, i.e., $36.7 million to the following UN agencies focusing on health-related issues: World Health Organization ($14.1 million), UNICEF ($13.5 million), UN Fund for Population Activities ($9.1 million) (CIDA, 2001). These figures do not include the health programming funding allocated by multilateral agencies such as the World Bank, the UN Development Programme, and regional development banks to which Canada provides financial support.

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7 These most recent numbers are comparable to aid to health by other bilateral donors which average 6%. However, the Development Assistance Committee of the OECD reports a lower level of Canadian commitment. Based on 1996-1998 annual average commitments to aid to health, Canada was allocating only 3% of its total aid to health (see annex, Table B).

In November 2001, the agency highlighted its priorities in its Action Plan on Health and Nutrition. The priorities identified in the plan are: improving food security and nutrition, improving access to clean water and sanitation, preventing and controlling communicable diseases, improving sexual and reproductive health, including safe motherhood, preventing and controlling non-communicable diseases (injury, tobacco, mental health) and strengthening health systems. The priorities are based on the principle of health as a human right and focused on those "conditions that affect the poor disproportionately" (p. 7).

The HIV/AIDS pandemic is widely recognized as a major obstacle to development, especially in Sub-Saharan Africa, and has received special attention in CIDA's health programming. CIDA's bilateral spending on this priority remains modest at $22 million in 2000-2001, but it is planned to increase to $80 million in 2005. In its HIV-AIDS Action Plan, the agency identifies a number of dimensions where its actions need to be strengthened. The low-risk, short-term and lower-yield interventions include supporting CIDA's and other Canadian diplomatic staff's efforts to increase political commitments from developing countries' national governments. Indeed, previous experiences in Uganda, Thailand and Senegal have demonstrated how political commitment is key to control the pandemic. Improving reproductive health programming, improving information, education and communications about the disease, giving greater attention to gender equality and human rights, to monitoring and evaluating the interventions, to care and support for children affected by AIDS and orphans and integrating HIV/AIDS in education programming are other proposals that the Action plan propose which can be relatively easily implemented with the proposed additional funding. Three other types of intervention are described as more expensive and risky, but offer great potential in the long-term: fast-tracking research on female-controlled prevention methods, promoting research and development for vaccine, and exploring cost-effective therapies for developing countries (including investigating incentives for pharmaceutical companies and increasing support for international efforts by WHO and UNAIDS).

9 These priorities are not hierarchized, as CIDA programming is demand and country driven. The allocation of resources for these priorities depends on demands from the receiving countries.
In 2001, at the United Nations held its General Assembly Special Session on HIV/AIDS (UNGASS), an international declaration of commitments was developed which called for increases in national budgets, research and debt relief to face the pandemic.\(^\text{10}\) It also established a global HIV/AIDS health fund to raise contributions from the public and private sectors. CIDA was involved in convening the early discussions to establish this Fund, which has since been renamed Global Fund to Fight AIDS, Tuberculosis and Malaria. The financial target set for the Fund was US$7 billion a year to tackle the diseases in low and middle-income countries. However, only US$1.9 billion has been pledged to date (February 2002). Canada has pledged US$100 million over the next four years to the fund.

To our knowledge, there is no academic literature examining and evaluating CIDA actions and strategies in the field of health. The potential sources of information are interviews with informed observers and officials. In interviews, CIDA officials highlighted a number of features of CIDA programming in the health sector. First, the focus has been and still is on building capacity in the communities where CIDA is involved, rather than focusing on physical infrastructures or other elements. One example of such capacity-building is the Regional AIDS Training Network which creates a network of institutions in East and Southern Africa to provide training in all aspects of HIV/AIDS response. CIDA’s approach to health was also characterized as rights-based and comprehensive (not exclusively medical), integrating for example the role of women’s education and gender equality in reproductive health programming in countries like Bangladesh. Finally, they stressed that Canadian official development assistance (ODA) on health is relatively small, but has been used as a leverage for larger initiatives such as the Global Alliance for Vaccines and Immunization and the Global Health Fund.

Our government interviewees also mentioned that the 2001 Action Plan on Health and Nutrition did not cause a major reorientation of the health programming of the agency, although it added new areas that were not covered by earlier strategy documents: non-communicable diseases and

\(^{10}\) Canada’s delegation to the Special session was headed by the Minister Maria Minna and officials from DFAIT, Health Canada, CIDA and two NGOs representatives. “Canada’s role gained relatively high marks from non-governmental organizations engaged in processes of pre-UNGASS consultation and preparation. Canada, along with Malaysia and Brazil were the only countries to place non-governmental representatives on their delegations as early as the first preparatory committee. The effective use of the non-governmental representatives on the
health systems. On the other hand, the non-government respondents we interviewed highlighted some of the weaknesses of the Action Plan and the general orientations of CIDA health programming. By focussing almost exclusively on specific projects and short-term results, CIDA does not offer long-term support for the development of health systems that are required to deliver health services and care. It was argued that the Action Plan lacks a clear philosophy; it highlights different areas for actions, but it is not articulated around a policy or a strategy. For instance, there is no recognition or promotion of the Canadian model of public health system, in which providing access to health care is an obligation and responsibility of the State, and not simply a service to be purchased by individuals. It was noted that this weakness may be symptomatic of the broader lack of vision at the international level. The WHO does not provide a rallying point on health, a strategy like the Alma Ata offered earlier on. The UN Millennium Development Goals may be important for mobilisation but do not offer a strategy on how to achieve these goals in the health sector. The recent Sachs report does not fill this policy vacuum either, but rather focuses on the quantification of the financial resources necessary.

Another weakness focuses on the implementation of the plan. One of the key problems here consisted in the very limited number of health specialists at CIDA to ensure that the policy orientation and priorities of the Action Plan take concrete forms in actual programming. Another specific criticism of the Action Plan on Health and Nutrition was highlighted by different non-governmental groups (NGOs) during the consultations and focused on the issue of malnutrition. Groups like Oxfam Canada were very critical of CIDA’s emphasis on micronutrient supplementation (such as Vitamin A supplementation), instead of a broader food security approach to malnutrition.

**Multilateral financial institutions and health**

Canada is involved in a number of multilateral discussions and activities on health. The Department of Finance is the lead agency for the relationships with the World Bank. CIDA participates in the elaboration of the Canadian positions at that forum, as well as having a number of ongoing bilateral and sectoral relationships with World Bank officials. The World delegation during negotiations, preparation of statements and the overall approach was also appreciated, although it had clear limits” (Foster, 2001).
Bank is the world largest external funder of health programs. Each year, the World Bank commits an average of US$1.3 billion per year in new lending for health, nutrition, and population projects in the developing world. Through its lending process, the Bank has become a very important provider of policy analysis and advice. "Over the past 15 years, the World Bank has become the most influential donor in the international health policy arena, actively promoting ambitious policy reforms ... The policy advice and in some cases, prescriptions, proposed by the Bank quickly became the baseline for debate and negotiation within states and between low and middle incomes countries and the donor community" (Zwi, 2000, p.167).

There is no literature examining the Canadian views and positions on the World Bank strategy on health nor are there primary documents available providing information on these positions. At the World Bank, Canada is represented in the formal decision-making body, the Executive Board, by one executive director. The Executive Board reviews and approves the Country Assistance Strategy (CAS) of the Bank, as well as discusses sectoral policy issues. However, there is no public information available on the voting of the executive directors or on the specific content of the discussions of the Board. Interview-based research on this topic would be interesting work for further research. A useful starting point would be for the Canadian government to publish a document stating in explicit terms the general orientations and the preferred specific policy options of Canada in terms of development assistance to health and health systems by multilateral organisations.

Canada and the Poverty Reduction Strategy Papers Initiative

Canadian development assistance is becoming increasingly linked to Poverty Reduction Strategy Papers (PRSPs). These PRSPs, already a condition for the HIPC (Heavily-Indebted Poor Countries) initiative of debt-relief, were launched by the World Bank (WB) and International Monetary Fund (IMF) in December 1999. They were presented as "a new approach to the challenge of reducing poverty in low-income countries based on country-owned poverty reduction strategies that would serve as a framework for development assistance" (World Bank/IMF 2002, p.4). Key elements of PRSPs include commitments to poverty-reduction (to the extent possible, linked to the Millenium Development Goals), broad public participation and local government "ownership." While there is broad support for PRSPs among multilateral
institutions, donors and many development NGOs, there are also concerns with several aspects of these programs. We believe Canada needs to attend to these concerns in its own use of PRSPs in its ODA commitments; and in its role approving such PRSPs at the World Bank and IMF.

Several development NGOs have expressed strong concerns that the degree of civil society participation in developing PRSPs has been minimal. Given the short time-period since their inception, and that 8 full and 41 interim country PRSPs have been completed, the pace of their development precludes wider civil society engagement.\(^\text{11}\) The most recent WB/IMF evaluation of the PRSP process acknowledges this problem, although also notes that public participation is slowly increasing, government "ownership" is strengthening and there is more transparent communication between governments and their citizens as a result of the PRSP requirement (World Bank/IMF 2002, pp.6-7). There have been several technical and development assistance challenges facing PRSPs, including the lack of adequate public budget and accounting structures in most affected countries (where is the money actually being spent?), off-setting costs of broader civil society participation, better prioritization of poverty-reducing targets and ensuring the programs actually do reach and benefit disproportionately the poor, avoiding a "governance imperialism" by donor countries stipulating in precise terms how recipient countries should govern themselves and a failure for many donor agencies to align more fully with the PRSP process, leading to many poor countries receiving little or no aid increase as a result of their PRSP efforts (World Bank/IMF 2000, 2002). There has been also serious concerns expressed by NGOs and organizations such as UNDP regarding the "pro-poor" quality of the macroeconomic framework used in these strategies (Jubilee South et al 2001, addendum to World Bank/IMF 2002, UNDP 2001, addendum to World Bank/IMF 2002).\(^\text{12}\)

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\(^{11}\) Ensuring fair and representative civil society in government consultations even in wealthy countries such as Canada remains a formidable challenge.

\(^{12}\) UNCTAD (2001, addendum to World Bank/IMF 2002), in its review of the PRSP initiative, cites a public statement by a World Bank official that "the PRSP is a compulsory process wherein the people with the money tell the people who want the money what they need to do to get the money;" and that this can lead to governments "second-guessing" what the Bank and IMF want to see, thus casting their PRSPs using the structural adjustment policies of earlier Bank and IMF lending conditionalities. Cheru (2001), in an assessment of PRSPs undertaken for UN Economic and Social Council, quotes a finance minister from one of the HIPC's, "We do not want to second-guess the Fund. We prefer to pre-empt them by giving them what they want before they start lecturing us about this and that. By so doing, we send a clear message that we know what we are doing, i.e., we believe in structural adjustment" (p.12).
A particular concern has been the inclusion of user fees for primary health care and education in some PRSPs (e.g. initially for Tanzania), despite even the World Bank acknowledging that this denies poor families access (Naiman 2001, Hilary 2001). According to Naiman (2001), leaked World Bank documents of the Tanzanian interim-PRSP led to NGO protest and, in the US, lobbying by certain legislators pointing out that, under October 2000 US legislation (itself a product of intense NGO and AFL-CIO lobbying efforts), US representatives to the World Bank and IMF could not support any primary health care or education program that included user fees. The Tanzanian interim-PRSP indicated that the poor would be exempt from such fees, but the issue raised by NGOs and others was extensive evidence that such exemptions schemes had failed (Naiman 2001, WHO 2001, addendum to World Bank/IMF 2002). Interestingly, the most recent WB/IMF PRSP evaluation credits the greater involvement of civil society organizations in rescinding user charge requirements for education in Tanzania (World Bank/IMF 2002), and holds out the promise that increased public participation in the PRSP process might also provide more creative solutions to the apparent conflicts between pro-poor and pro-growth policies.

The World Health Organization goes further in analyzing serious gaps in existing PRSPs with respect to health (WHO 2001, addendum to World Bank/IMF, 2002). Amongst its major criticisms:

- PRSPs deal with ill health as a consequence of poverty, but not also as a cause of poverty, particularly with respect to the effects of cost-recovery or user-charges for health care services on the poor. Six of the ten PRSPs reviewed by WHO referred to the need to subsidize cost-recovery health services for the poor, but failed to mention any of the well-known failures of such fee-exemption programs, despite these issues being raised in the public participatory documents associated with these PRSPs.

- The PRSPs do not deal with such important health system issues as governance (e.g. government doctors also working privately), and expenditure levels well below the minimum of $30 - $40/capita needed to provide basic primary health care; and there is no indication that the PRSP process is leading to any increased commitments in health or education.
• PRSPs deal only with health as an outcome of development, rather than a means of
development. This prejudices investments in health as secondary to investments in economic
growth (macroeconomic) policies.

• Several PRSPs, in identifying these growth policies, such as increased agricultural
production for export, increased mining and increased road construction, make no link to the
health implications of these, respectively, nutrition and food security, occupation health and
safety and traffic accident prevention.

The WHO specifically recommends that PRSPs adopt a "pro-poor" health strategy, comprised of
the following elements:

• Reduce the financial burden of health-care use on the poor.
• Reallocate resources in favour of poorer regions.
• Combat diseases of the poor.
• Prioritize reproductive and child health.
• Prioritize HIV/AIDS.
• Improve the impact of public health services.

In addition, the WHO concludes that "explicit health objectives need to be incorporated into
sectors which influence - and are influenced by - health," i.e., that PRSPs incorporate a health
promotion/population health determinants approach. Significantly, WHO’s recommendations
are very much coherent with Canadian health care health determinants policies, Canada’s
international leadership in development of health promotion/population health approaches and
Canadian health values.\(^{13}\)

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\(^{13}\) This is also a recommendation advanced by the Coalition for Global Health Research – Canada
(CGHRC), described in the next section of this paper. The Coalition urges that global health research,
specifically, and global health programs, generally, ensure that the "burden of disease" (disease-specific
problems) are always addressed in the context of the "inherently global health issues" or broader
determinants (economic, political, environmental) that conditions disease risk and treatment options
(Labonte and Spiegel, 2001).
Section 3 GLOBAL PUBLIC GOODS FOR HEALTH

Basic definitions

Inge Kaul, lead analyst on global public goods for the UNDP, recently expressed, "In today’s world, globalization has brought about interdependencies that blur the distinction between domestic and external affairs. The best way to ensure one’s own well-being is to be concerned about that of others" (Kaul and Faust, 2001; p.869). This reiterates the points raised in our introduction: That diseases, and disease inequalities, in other countries pose direct risks to Canadians’ personal and population health and indirect risks via regional political insecurity and consequent threats to global security. The concept of "global public goods" (GPG) has been advanced as a perspective that would aid policy analysis and practice on such a premise. GPG is a relatively new expansion of the classical economic construct of public good. GPGs for Health is even more recent, and still in pursuit of definitional clarity. In this section, we briefly review recent discussions on GPGs for Health, and then assess its implications for Canadian policy through a number of case exemplars.

In common use, public good is often associated with "the common good," or with such value-based goals as social equity, social justice and environmental sustainability. Its definition in economic theory is narrower, more precise, and contrasted specifically to "private goods." A private good is one whose individual consumption is both excludable (my use of the good is not dependent on others’ use) and rivalrous (my use of the good could preclude use by another). This characterizes most market-based commercial/commodity exchanges. A public good is one that is non-excludable (which includes most common pool resources, such as air, water, biodiversity, peace and even – the classic example often used to illustrate a public good - the traffic order created by traffic lights); and, in "pure form," also non-rivalrous (although most common pool resources do entail potential rivalry as supply diminishes, or efforts are made legally to convert them into private goods) (Spicer, 2001).

In practice, the boundary between public and private goods is harder to pin down, since many transactions have both private and public effects. Access to nutritious meals, for example, primarily improves individual health (private good); but this improvement, in turn, contributes to
better population health (which most economists define as a public good). It is also generally accepted that many private goods carry public bads (negative market externalities) ranging from pollution to social inequalities, which require publicly funded regulation and/or "public good" remediation; a global public bad *ipsos facto* defines a compensatory global public good. It is also possible that GPGs in one domain (such as global trade rules, which may increase economic growth, universally accepted by economists as a public good) can simultaneously create global public bads in other domains (such as increased global resource depletion or income inequalities). We return to this point a little later.

Efforts to distinguish national or regional public goods from global public goods are also problematic. Aid efforts to alleviate poverty in Sub-Saharan Africa will produce national or, at best, regional public good effects. But such aid might also be considered a global public good to the degree that reduced poverty rates allows for more stability, peace and security in the region, and hence globally. Individual poverty itself is not a public bad, but its contribution *inter alia* to degradation of the environmental commons or to conflict through loss of social cohesion creates a number of potential public bads making poverty eradication a public good. Similarly, malaria control efforts are not GPGs in themselves because the disease is regional, although with climate change its regions are expanding. Such control efforts might still be construed as indirect GPGs because malaria creates a disincentive for investment and trade, and so dampens the global public good of increased economic growth (Kaul, 2001; Kaul, Grunberg and Stern, 1999).

**What are global public goods for health?**

Difficulties in determining precisely what might constitute GPGs for health has not precluded efforts to define possible candidates. David Woodward (2001), development economist with the World Health Organization, identifies five broad categories of GPGs:

- **Environment:** This would include the "intermediary global public goods" (IGPGs)\textsuperscript{14} of the many multilateral environmental accords, such as the Kyoto Protocol, the Convention on Biological Diversity and Rio Agenda 21, and those agencies responsible for their oversight.
• Health: This would include the IGPGs of multilateral declarations on health, as well as social and environmental declarations pertaining to health’s "underlying determinants" (as discussed in Section 1 of this paper).\textsuperscript{15}

• Knowledge: Human capital formation, hence the many IGPGs associated with multilateral commitments to education as a human right, such as ensured under the Universal Declaration on Human Rights and the Convention on the Rights of the Child and, more recently, through the Framework for Action of the Dakar World Education Forum, and the G8 Digital Opportunities Taskforce.\textsuperscript{16}

• Peace and security: This would include all of the determinants of peace and security, and the UN agencies acting upon those determinants; "world peace is perhaps the clearest global public good" (Bradley, 2001; p. 3).

• Efficient markets: This includes multilateral trade rules administered by the World Trade Organization.

Global trade rules are similarly identified by Kaul (1999) and especially Birdsall and Lawrence (1999) as GPGs (or IGPGs), although the latter’s analysis is incomplete as it does not assess the global public bads (social and environmental externalities) associated with increased trade liberalization and behind-the-border "deep integration" or "trade creep" of WTO rules.\textsuperscript{17}

\textsuperscript{14} Coined by Kaul, Grunberg and Stern (1999), an intermediary global public good is the institutions and rules established to ensure provision of the "endpoint" global public good.

\textsuperscript{15} Not all economists agree that health \textit{per se} is a global public good (e.g. Spicer, 2001). Rather, health may be instrumental to accomplishment of other GPGs, such as economic growth.

\textsuperscript{16} Knowledge is often considered the "purest" public good, but only to the extent that its accessibility is not constrained (made excludable) by intellectual property rights. Economists disagree on whether education is a public good or simply that in many countries it is a private good that is publicly provided. But if lack of education access in a private market precludes access to knowledge, then the public provision of education can be seen as an essential foundation for knowledge as a GPG. Similar arguments apply to the public provision of health care.

\textsuperscript{17} Once again, it also highlights the lack of definitional consensus on GPGs. In the same volume that Birdsall and Lawrence dismiss attaching labour and environmental clauses to trade liberalization agreements as a global public bad (because it dampens economic growth in poorer countries more willing to accept poorer labour and environmental standards – though that itself is a moot point), Kapstein (1999) argues that labour standards and worker compensation linked to trade liberalization agreements \textit{is} a GPG by virtue of increasing global distributive justice (p.105).
Sandler and Arce (2000), in their Working Paper on GPGs for Health for the Commission on Macroeconomics and Health, take a more restrictive approach to defining a GPG. In their typology, a cure for a disease is a GPG, especially an infectious disease which, unlike a chronic illness, poses a direct risk to others. A treatment regime for malaria is not a GPG, however, since its benefits are primarily national or regional. Yet, like Kaul, they argue that infectious disease (including malaria, and HIV/AIDS) in Sub-Saharan Africa constitutes a global public bad for its dampening effects on economic growth. Hence, malaria control programs (intervention, research) constitute a GPG. They also argue that globalization-related income inequalities may be a partial source of higher disease rates, and so may also be a global public bad. Sandler and Arce list seven basic GPGs for health:

- cure for disease
- new treatment regime for disease
- control of air and water pollution emissions\(^{18}\)
- uncovering basic research findings
- monitoring disease
- disseminating research findings
- curbing epidemics

Sandler and Arce also identify two other categories of potential (but not pure) GPGs\(^{19}\):

- Joint products: Where the activity produces a private good with indirect global public good effects, such as sharing surveillance data, immunizing populations and deploying health-care workers abroad (where the "private" national benefit are the remittance incomes).
- Merit goods: A particular subset of joint products where the activity produces a national public good, again with indirect global public good effects, such as providing

\(^{18}\) Elsewhere, Sandler (1999) identifies environmental GPGs which, though he doesn’t specify as such, have indirect but significant health effects, including ozone shield protection and global warming prevention.

\(^{19}\) “Impure” public goods are those that are not completely non-excludable and non-rivalrous.
universal health care which has "private" national benefits but indirect global "public good" in the form of healthier, more economically productive people, and prevention of global public bads such as treatment resistant tuberculosis.

By this reasoning, foreign aid (especially directed towards health infrastructure and disease reduction), disaster relief, drug interdiction (or, more generally, interdiction of trans-border flows of products posing health risks) and poverty alleviation are partial GPGs.

Bradley (2001), in his essay for the Commission on Macroeconomics and Health, discusses four "unequivocal" GPGs for health:

- Disease eradication
- Disease research
- Disease surveillance and information (including sharing)
- Expertise development (ensuring trained people for the three GPGs above exist in every country, with implications for official development assistance (ODA) and health professional recruitment strategies)

The WHO Commission on Macroeconomics and Health (2001) identifies GPGs in similarly narrow terms, and locates funding for these GPGs primarily in the World Bank and the World Health Organization, arguing for increased annual funding of $1 billion by 2007 and $2 billion by 2015. The GPGs financed through this increase include:

- International disease surveillance
- Data collection and analysis of global health trends (burden of disease)
- Analysis and dissemination of global best practices in disease control and health systems
- Technical assistance and training

This funding is separate from the $1.5 billion annually called for in global health research (the "Global Health Research Fund"); and both are separate from the Commission’s major recommendations for targeted disease interventions. To the extent these interventions are effective in reducing the burden of disease (primarily in Sub-Saharan Africa), they can be
considered indirect GPGs for reasons already discussed. Moreover, the Report emphasizes that this investment in GPGs must not be at the expense of ODA expenditures that, routinely and historically, have gone to more national or localized initiatives with only marginal or indirect GPG spillovers.

Finally, not all writers on GPGs take a narrow definitional stance. Rao (1999), another development economist who has done extensive work for the UNDP, argues that equity is the fundamental prerequisite to the provision of public goods, whether national or global; and that ipso facto inequity (inequalities), which are primarily by-products of market transactions, are a global public bad requiring concerted national and global intervention through, in part, "distributive bargains" (p.82). While still constructed as economic discourse, Rao’s argument begins to bridge into values-based reasoning. Sen (1999a), in turn, highlights the important role of non-state and non-official multilateral actors (i.e., non-governmental organizations) as providers of GPGs. These range from corporate organizations promoting socially and environmentally responsible business ethics, to feminist networks generating critiques of discriminatory practices of governments or private companies (the "products" of such groups are the GPGs). The central issue for Sen is how to make normative assessments of the legitimacy of such non-state "plural affiliations," which he argues should be made on the basis of social justice norms, including "the Difference Principle:" that historically less advantaged individuals warrant priority in the "holdings" of "primary goods." By extension, international treaties or covenants, institutions and civil society organizations working for re-distributive justice (the Difference Principle) constitute GPGs.

**Implications for Canada’s role in provision of global public goods for health**

There are two points important to recognize at the outset: There are no specific legal or other multilateral non-binding commitments to the provision of global public goods per se to which Canada is a party. Many of Canada’s legal and other multilateral commitments (in the form of multilateral environmental and social accords, trade agreements, peace and security commitments), however, constitute a commitment to providing a global public good, though not in name. Fidler (2002a) provides a "non-exhaustive list" of global public goods for health, and their related international legal regimes (Table 2).
Table 2

<table>
<thead>
<tr>
<th>Examples of Global Public Goods for Health</th>
<th>Related International Legal Regimes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control of international spread of infectious diseases</td>
<td>International Health Regulations (1969)</td>
</tr>
<tr>
<td>Food safety in international trade</td>
<td>WTO Agreement on the Application of Sanitary and Phytosanitary Measures (SPS) (1994)</td>
</tr>
<tr>
<td>Occupational safety and health</td>
<td>International Labour Organization Convention C155 on Occupational Safety and Health (1979)</td>
</tr>
<tr>
<td>Control of the international flow of narcotic drugs and psychotropic substances</td>
<td>UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988)</td>
</tr>
<tr>
<td>Reduction of transboundary air pollution</td>
<td>Geneva Convention on Long-Range Transboundary Air Pollution (1979)</td>
</tr>
<tr>
<td>Access to public health and health care services</td>
<td>International Covenant on Economic, Social and Cultural Rights (1966)</td>
</tr>
</tbody>
</table>

There remains some scepticism about what a GPG perspective adds to our understanding of national obligations for global health not already covered by human rights or development approaches (comments by delegates to IDRC/CIDA/Health Canada/WHO Workshop on Global Public Goods for Health, Ottawa, June 4-6, 2001). It appears, however, that a GPG perspective:

1. Sharpens the focus for increased Canadian commitments to certain key GPG initiatives.
2. Calls for creating greater coherence in Canada’s use of trade agreements, which have both global public "good" and global public "bad" applications.
3. Implies increased support to IGPGs (Intermediary Global Public Goods, such as the World Health Organization and Pan-American Health Organization), indirect GPGs (such
as ODA for development of health infrastructures in poorer countries), and increased civil society participation in formulation of actions in each of the first two areas.

**Key GPG Initiatives: Global action on tobacco control**

Not all analysts regard tobacco control as a GPG, since the negative effects of tobacco use are primarily private bads or, when public (e.g. higher health care costs, second-hand effects, lost productivity), are confined within national borders. Chronic diseases, unlike infectious diseases, do not have immediate cross-border spillovers. Moreover, they are most likely to afflict people when they cease making substantial contributions to economic growth, unlike many infectious diseases (Kaul, 2001; Spicer, 2001). This logic, however, requires erecting arbitrary borders around calculating the externalities (i.e., the public bads) of chronic diseases, or the role of tobacco in increasing disease risk. Tobacco use may be associated with net economic loss (a public bad) and with higher health care costs. These costs could reduce national governments’ abilities to finance resource transfers that reduce income and health inequalities within their borders, bearing in mind that such inequalities are generally accepted as contributing to public bads. By this reasoning, tobacco control could be considered a GPG.

This is certainly how most organizations associated with developing the International Framework Convention on Tobacco Control (FCTC) characterize the Convention. Canada has been a key international player on tobacco control, supporting the development of the FCTC currently being negotiated at the WHO. The Framework would be a legally binding treaty on collective international action and co-operation on tobacco control. The negotiations are planned to be completed in 2003 and would lead to the first such treaty convention adopted by WHO members. Health Canada is the lead for Canada in the negotiations and for the national consultation process feeding into these negotiations.\(^\text{20}\)

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\(^{20}\) Other elements of our international tobacco control policy include grants to international organizations working on tobacco control and the International Development Research Centre’s (IDRC) research on tobacco control in developing countries.
Trade and tobacco control conflicts

There are conflicts, however, between Canada’s domestic and foreign policies and approaches to tobacco control, and its trade agreement commitments. Canadian international trade commitments can limit the types of tobacco control measures that can be adopted by the Government (Callard et al., 2001). In 1994, the Canadian government proposed the adoption of generic packaging for cigarettes. Tobacco companies responded that such a measure would violate their intellectual property rights, i.e., their trademarks, which are protected by the WTO and NAFTA agreements on intellectual property. After the submission by the tobacco industry of a legal opinion prepared by Carla Hills, former US Trade Representative, the federal government abandoned this proposal. More recently (March 2002) Phillip Morris International indicated that it believes proposed Canadian regulations to prohibit use of the terms "mild" and "light" on tobacco packages would violate NAFTA 11:1105 (unfair expropriation) and 1110 (measures tantamount to expropriation of reasonably expected profits); as well as Article 20 of TRIPS (unjustifiably encumbering use of a trademark) and Article 2.2 of the Agreement on Technical Barriers to Trade (creating unnecessary obstacles and not being in the least trade restrictive method) (BRIDGES Weekly Trade News Digest 6:1, April 9, 2002; p.9). Canadian health groups involved in the FCTC negotiations propose to clearly state that the FCTC would have legal precedence over trade agreements, if a conflict arises.

The FCTC’s linkage with or precedence over trade agreements is still being negotiated and debated at the WHO. Fidler (2002b) questions "whether the framework-protocol [such as the FCTC] provides an adequate foundation for such international legal evolution is still open to question" (p.56). Apart from the decline in nations participating in or ratifying the more demanding protocols that follow adoption of the generally worded framework treaty, there are presently no enforcement measures for countries that fail to abide by the protocols. Trade agreements, however, have enforcement mechanisms. This underscores the necessity for governments participating in framework-protocol conventions on health, such as the FCTC, to clarify in both the convention and in their domestic legislation, their legal precedence over trade disputes. The Canadian position on this issue is not established yet. There is some urgency in this matter, in light of the leaked European Commission’s WTO negotiating proposal that
distribution of tobacco products should be committed for full liberalization under GATS, not only in Canada but also in many developing countries, including China, Korea and Mexico.\(^{21}\)

There are also Canada’s obligations - at this time only moral - not to contribute to increased global tobacco consumption as a global public bad. Inclusion of Canadian tobacco exporters on a Team Canada February 2001 trade mission to China is clearly inconsistent with its engagement in negotiations on the FCTC, and its domestic efforts to reduce tobacco consumption by, in part, reducing growth in the number of new smokers. Liberalization of tobacco trade in developing countries, though rationalized as competition for the market of current smokers, invariably leads to increased consumption and increased numbers of new smokers (Chaplupka and Laixuthai, 1996; Taylor et al., 2000).

*Global health research*

Knowledge is a clear GPG. Research that finds cures for disease, ways to lower disease risk and improves policy-relevant understanding of disease-determining social or environmental conditions similarly constitutes a GPG. Kaul (2001) argues strongly that global health research is GPG. She notes that the "10/90" research gap - where 90% of health research goes to 10% of the health problems affecting the world’s wealthier citizens - cannot be met by market-based incentives or intellectual property right protection, such as TRIPS, since the problem is due to the poverty of people and governments who might eventually purchase such pharmaceuticals. This point was underscored by the WHO’s Commission on Macroeconomics and Health (CMH), which noted that "poor-country governments lack the means to subsidize R&D, and patents protection means little when there is no significant market at the end of the process" (WHO, 2001, p.77). Some drug companies are engaged in research on some of these diseases, but the scale of this research remains insufficient to match the scope of the problem. Some international mechanisms have been created to face this problem, but they remained profoundly under-funded. The budget of one of the main initiatives, the Special Programme for Research and Training in

\(^{21}\) While only an initial position by the EC, it extends beyond tobacco to include liberalization in alcohol distribution, wholesale and retail sales. Alcohol is one of four new topic areas (alongside the rights of mentally ill, funding for global vaccines and improving access to essential drugs and vaccines) where there is momentum to create new framework treaties (Fidler 2002a). How might such a convention be limited by existing GATS liberalization commitments, should the EC succeed in its proposals?
Tropical Disease of the WHO, UNDP and World Bank, is about $30 million per year to cover eight tropical diseases.

Canada recognizes the importance of health research and provides modest funding for these initiatives. CIDA provided $1.4 million to the Tropical Disease Research Programme in 1999-2000 and $350,000 to the Special Programme of Research and Development in Human Reproduction. CIDA also recently signed a Memorandum of Understanding (MOU) with the Canadian Institute on Health Research, Health Canada and International Development Research Center (IDRC) in support of Better Health for the Poor: A Canadian Collaboration for Global Health (November, 2001). The four Canadian organizations agreed to collaborate on global health research. They will provide funding for research on tropical diseases and other health problems specific to developing countries to be conducted by researchers in Canada in collaboration with researchers in developing countries. The level of funding for this new global health initiative has yet to be established, although different members of the MOU have already begun to increase their commitments. Health research funding provided by IDRC, which amounted to $5.7 million last year, is projected to increase by at least $1 million this year. The CIHR will shortly be announcing a special competition in global health research linking north-south health researchers and institutions.

The CMH (WHO, 2001), as noted earlier, recommends creation of a new $1.5 billion a year fund "Global Health Research Fund." This fund would supplement existing funds and initiatives, such as GAVI (the Global Alliance for Vaccines and Immunization) and GFATM (the Global Fund to Fight AIDS, Tuberculosis and Malaria) which are primarily for program implementation rather than research. (The CMH also recommends that these other initiatives have their funding increased by $1.5 billion a year.) The Canadian government has not yet announced an official response to the CMH report. CIDA officials do not see any important contradictions between what the report proposed and the current orientations of Canadian development assistance for health. Support for such research should not come at the expense of increased ODA for development of health infrastructures. Indeed, the targeted interventions recommended by the CMH presume that such infrastructures are by and large in place; and experiences with GAVI (the immunization campaign) indicate that much of its potential can be thwarted unless health
infrastructures are simultaneously developed at a similar scale and pace. At the same time, increasing global health research knowledge should not wait until perfect infrastructures are in place. Moreover, as the recently formed Canadian Coalition for Global Health Research (CCGHR) argues, developing this knowledge in partnerships with Canadian and southern researchers is important for enhancing the knowledge capacity in poorer nations.

The CCGHR, whose membership includes researchers and program development workers from universities, government agencies and non-governmental organizations, works closely with the four institutions (IDRC, CIDA, Health Canada and CIHR) that recently signed the MOU on global health. The CCGHR, and the four funding partner institutions, have urged Canadian government support for the Global Health Research fund generally, and that 1/3rd of its $1.5 billion annual target be designated as a special fund for African health research, with management for the fund by a reputable African institution or network. The groups are also urging an immediate tripling of bilateral and multilateral funding for global health research (CCGHR, 2002).

*International health regulations*

The cholera pandemics of the 19th century that clearly established the links between trade and disease risk - and the sometimes contradictory imperatives between disease control and trade liberalization - also gave rise to the first set of international health treaties. These treaties were intended not only to curb the spread of disease, but also to ensure that merchants in any one country shared equally in economic costs of complying with control measures, avoiding the classic economic problematic of the "free rider" (Fidler, 2002b). Current International Health Regulations (IHR), drafted in 1969, refer only to three diseases: cholera, yellow fever and dengue. The IHR is the only international health agreement on communicable diseases binding on WHO member states. IHR functions to control cross-border disease spread through two mechanisms: surveillance and notification of outbreaks, and maintenance of public health facilities at border crossings. Fidler (2001) argues that the existing IHR has failed for four reasons: first, the narrow range of diseases; contemporary health risks associated with HIV/AIDS, tuberculosis, malaria and even pneumonia are absent. Second, states failed to notify of outbreaks even of the three required diseases. Third, irrational measures against states with
outbreaks sometimes occurred. Fourth, WHO Member States failed to apply any enforcement against non-complying countries. The IHR has been under revision since the late 1990s, with latest proposals calling for governments to report on "public health risks of urgent international importance" which could include more than infectious diseases (Fidler, 2002b). IHR revisions, however, have not attracted much government, media or NGO attention – despite the rising concern over global spread of infectious disease.  

**Greater coherence, trade agreements as GPGs and other GPGs for health**

This brings the discussion to the impact of the World Trade Organisation and its agreements on health as a GPG. As Fidler (2002b) points out "the combination of the multiple interfaces between the WTO agreements and public health, combined with the revolutionary dispute settlement mechanism, put the WTO in a much more powerful international legal position than WHO with respect to global public health. From the international legal position, the center of power for GHG [global health governance] has shifted from the WHO to the WTO." This is particularly so when one considers the broad range of social and environmental conditions that constitute key health determinants, such as poverty, inequality, environmental risks/pollutants, education; that trade agreements are IGPGs themselves for the greater global economic growth they engender.

The basic health argument supporting increased trade liberalization is that free trade promotes economic growth. This, in turn, reduces poverty, and so promotes health; and generates more potential revenue for public health, education and other national "public goods" for health (Dollar, 2001). This economic growth, however, is also likely to increase inequality (though there is still empirical disagreement on this question) and whether it improves health depends on the social, political and economic environments in which it occurs. Nobel economist, Amartya Sen, noted in his address to the 1999 World Health Assembly that much rests on how the income generated by economic growth is used, "in particular, whether it is used to expand public

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22 Fidler (2001) attributes this to, *inter alia*, the ability of communications technology and involvement of many NGOs in disease surveillance to reduce reliance on mandatory government reporting, a retreat to "soft law" recommendations (rather than "hard law" requirements) to governments experiencing such "public health risks," and the incursion of trade agreements, particularly the Agreement on Sanitary and Phytosanitary Measures (SP), into the realm of international public health regulation.
services adequately and to reduce the burden of poverty" (Sen, 1999b). Moreover, even if or when economic growth improves health in the short-term, there are longer-term environmental and social costs to such growth (negative externalities, or global public bads) that can reduce health. 23

Section 1 of this paper already raised fundamental points of conflict between trade agreements and human rights. Table 2 above identified a number of multilateral environmental agreements (MEAs) that constitute GPGs for health. There remains lack of clarity between WTO trade rules and MEAs. This issue was partly addressed in the WTO’s 4th Ministerial Doha Declaration (November 14th, 2001), which calls for "negotiations, without prejudging their outcome, on: (i) the relationship between existing WTO rules and specific trade obligations set out in multilateral environmental agreements…" The Ministerial Declaration, however, provides no indication whether MEAs would (or should) be superordinate when there are conflicts with trade agreements, nor does it define what is meant by a "specific trade obligation" within an MEA. It does hold out the option of granting observer status to certain MEA Secretariats and the UNEP in the WTO Committee on Trade and the Environment, although this is still being negotiated and the extent of their role (provide information only, participate in dialogue) remains uncertain (BRIDGES Weekly Trade News Digest, 6(17) 7 May, 2002). Canada’s position on this issue is not known.

Leaving aside the issue of TRIPS (taken up in Section 4 of this paper, as well as in the second research paper by Shrybman, Sanger and Lexchin) and the effects of trade agreements on health services (the primary focus of the second paper), there remains the general fact that WTO rules affect the use of public health measures. We deal here only with two specific instances of this: The Sanitary and Phytosanitary Agreement (SPS), and GATT Article XX(b), which may permit exceptions to the general GATT rules "necessary to protect human, animal or plant life or health." We specifically examine Canada’s involvement in SPS and GATT XX(b) disputes.

23 For a recent discussion of these issues as they affect global health, see Labonte and Spiegel, 2001.
**GATT XX(b) and the Asbestos Case**

Article XX(b) of GATT permits exceptions to the general GATT rules "necessary to protect human, animal or plant life or health." This exception had been narrowly interpreted by WTO dispute panels with the only ruling, the Canada/France asbestos case, upholding a trade ban. In 1998, Canada challenged the ban on asbestos adopted by the Government of France and requested a WTO panel to examine whether this measure was inconsistent with a number of its trade obligations. Canada claimed that France was discriminating Canadian-produced chrysotile asbestos against French-made substitute fibres that also present potential health risks. Canada argued that France adopted an excessive measure, as the risk to human health posed by asbestos was minimized when the product was handled and used carefully (safe use approach). The WTO panel and the appellate body both sided with France and stated that "controlled use does not constitute a reasonable alternative to the banning of chrysotile asbestos that might be chosen by a decision-maker responsible for developing public health measures" (WTO, 2000). The panel agreed that the measure was discriminatory, i.e., that Canadian asbestos and substitute fibres were "like-products," but that given the consensus within the international health community on the carcinogenic nature of asbestos, France was entitled to resort to the human health exception provided under GATT XX(b). (It is important to note that such scientific certainty is rarely the case with many human health risks associated with tradable goods.) As one of the leading exporters of asbestos, Canada challenged the French ban for fear of an international ban (Drache and Singh, 2001). Several health, labour and environmental groups in Canada and abroad were very critical of this challenge, regretting the lack of balance between commercial interests and public health interests in this matter. Canada’s appeal was rejected by the WTO in April, 2001.

**SPS and the Beef Hormone Case**

The Agreement on the Application of Sanitary and Phytosanitary Measures (SPS) is not a health agreement. Its stated goal is to prevent the use of SPS measures as disguised barriers to trade. Some analysts presented it as a trade agreement limiting the application of health regulatory standards that may impede the trans-border flow of food items.

[T]he SPS targets only the overuse of national health regulations. Thus, a government that abandoned all health regulations would not be in violation of the SPS. Governments do not violate the SPS by permitting exports unsafe for the foreign consumer (Charnovitz, 2001, p.2).
The SPS requires that countries base their regulatory standards on a scientific risk assessment. This higher order of scientific certainty than that governing GATT Article XX(b) is thought to be one reason by the European Commission (EC) lost to the US and Canada on its attempt to ban imports of hormone-treated beef. The WTO dispute panel rejected as inadequate the scientific arguments presented to them by the EC, specifically ruling that the EC had failed to present an adequate risk assessment (Sullivan and Shainblum, 2001; Charnovitz, 2001). The SPS Agreement also encourages Member States to adopt standards developed by international organizations in establishing trade-restricting health measures, in this instance, those of the Codex Alimentarius Commission (Codex). Codex is a joint effort of the WHO and the Food and Agricultural Organization (FAO), and its rules can be considered an IGPG (intermediary global public good). Although Canada’s position appears to maintain that the SPS beef hormone ruling was appropriate, i.e., that the EC’s objection to hormone-treated beef was disguised protectionism and genuinely about public health protection, there are several aspects to both the SPS and the beef hormone case that have raised concerns within the public health community.

First, "the SPS subjects non-discriminatory domestic measures to supervision whenever they affect trade" (Charnovitz, 2001, p.1). This is the phenomenon referred to as "trade-creep," where the intent is no longer to ensure that foreign products are allowed free entry and are treated no differently than domestic products. Rather, it allows exporting countries to challenge how national governments set their own domestic standards.

Second, these standards must be "based on scientific principles" and cannot be maintained "without sufficient scientific evidence" (SPS Article 2.2). The EC bans the use of growth hormones on its domestic beef products, but Canada and the US argued that this ban was not scientific. The necessity test in the SPS is a "risk assessment" (SPS Article 5.1) and litigation under the SPS has won principally because the WTO dispute panels and Appellate Body found that the challenged country had failed to undertake an adequate risk assessment proving harm. But it is not clear how the adequacy of such assessments should be adjudicated. For example,

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24 Concerns remain, however, over how such rules are formulated. Non-governmental organizations and independent (academic) food researchers, for example, have long complained that Codex membership includes a disproportionately large number of representatives from the food industry, with potential interests in regulatory decisions that do not impact negatively on their products.
evidence that hormones were "safe" was based on the assumption that they would always be used in accordance with "good veterinary practice" (Charnovitz, 2001, p.4); did not include studies examining the synergistic effects of growth hormones on naturally occurring hormones, or effects on infants or children more susceptible to carcinogens (Caldwell, 1997); and apparently did not find convincing conclusions by the International Agency for Research on Cancer that exposure to several of the hormones at issue may cause human cancer and/or have carcinogenic effects in laboratory animals. The Appellate Body did hear from a US expert with the National Institute of Environmental Health Sciences (Dr. George Lucier) that one in every one million women would develop breast cancer from eating hormone-treated beef but either "dismissed Lucier’s opinion as unscientific, or adjudged a one-in-a-million risk to women to be unimportant" (Charnovitz, 2001, p.5).²⁵ It is important to bear in mind that dispute panel and Appellate Body members are not scientists, yet are in a position of making judgments on the adequacy of scientific study.

Third, the burden of any error in an SPS dispute panel decision is borne entirely by the affected importing country. The exporting country has nothing to lose. If hormone-treated beef is found to harm human health, the affected individuals and the EC bear the cost, not the producers or exporting country. In another SPS case, Canada successfully challenged an Australian ban on Canadian salmon imports, much of it farm salmon, arguing, in part, the low risk of new diseases inadvertently getting into the wild salmon in Australian salmon.

Suppose that Australia complies with the WTO ruling, allows in Canadian salmon, and then suffers a huge loss from foreign salmon disease. Who would bear the cost of the WTO panel being wrong about the danger of alien pathogens? Surely not the panel. Not the Canadian exporter, nor the WTO. No, it would be Australians that would suffer that liability. Right now, defendant countries like Australia have nothing to gain from SPS litigation and plaintiff countries like Canada have nothing to lose (Charnovitz, 2001, p.8).

Fourth, the Appellate Body in the beef-hormone dispute acknowledged that the precautionary principle may be part of customary international law – the position argued by the EC – but that the principle lacked authority in health law (unlike environmental law) and that it "had not been written into the SPS Agreement as a ground for justifying a measure that otherwise violates the

²⁵ The dispute panel did defer to the Codex regulations that adopted standards for growth hormones
SPS” (Charnovitz, 2001, p.8), i.e., the precautionary principle may have no bearing in an SPS dispute.

The existence of public health concerns with the narrow application of GATT XX(b) and several aspects of the SPS call into question Canada’s role in participating in disputes under these two Agreements. The increased deference to international standards, such as Codex, by SPS dispute panels is problematic. International standards for pesticide residues, for example, are generally much less stringent than those adopted by the US (which we presume approximates Canadian standards) (Caldwell, 1997); at some point, Canada could face challenges to its domestic health regulations, especially if these have been formulated in the absence of comprehensive risk assessments which, while helpful tools in policy-making, are costly and methodologically controversial.

The question of when general health exceptions (including the precautionary principle) are disguised protectionism lies at the heart of disputes under GATT XX(b) and the SPS (and, to a lesser extent, the Agreement on Technical Barriers to Trade). One important means of improving the odds that trade does not trump public health in such cases is to reverse the burden of proof in all such disputes. The onus could be on the disputing country to prove the exception was not intended to protect human or environmental health (GATT XX(b)), i.e., that its intent is protectionist; or, in the case of SPS, to provide risk assessments indicating a product disallowed on health grounds in one country is safe.26 Many health non-governmental organizations (NGOs) argue that a reverse onus should apply. This is a position also supported by the Government of Canada, which proposes guidelines for the precautionary principle to include that, "Generally, the responsibility for providing the scientific information base (the burden of proof) should rest with the party who is taking an action associated with potential or serious harm" (Government of Canada, 2001b). Some argue further that, since most WTO disputes emanate from the US, the EU and other wealthy nations (no African country has yet filed a WTO

26 Scientifically, the proof would be risk assessments failing to show demonstrable harm, although this quickly raises the problematic of "acceptable risk." As the Government of Canada (2001b) notes about such risk assessments, "It should be recognized that it is impossible to prove a negative (e.g., to prove categorically that something will cause no harm, or to prove with absolute certainty that something bad might not happen or to prove that something is not harmful), but possible to demonstrate that "reasonable testing" was done with no evidence of harm.”
complaint), costs associated with filing a complaint should be born by the wealthier disputant (Labonte, in press).

**Increased support for intermediary GPGs, including civil society participation**

That the WTO is now arguably the more powerful legal actor in defining GPGs for health does not mean that Intermediary GPG institutions such as the WHO and PAHO (Pan-American Health Organization) are unimportant. Canada currently provides funding and participates in both the WHO and PAHO (contributing about $US10.2 million annually). The WHO administers several important GPGs for health, and provides important technical information to Member States. Its work on the FCTC announces a new role for the WHO in formulating international health law. Just as Canadian trade negotiators could urge a strengthened role for UNEP and MEA Secretariats in WTO meetings where trade negotiations could impact the environment, they could also advocate a stronger WTO presence by the WHO. More specifically, both the WHO and PAHO have small groups undertaking research and analysis on the trade - health linkage. The work of these groups includes research, policy analysis, training, Member State consultations, documentation of "best practices" (with respect to integrating health concerns in trade agreements/negotiations) and support for global networks of trade – health researchers and policy analysts. Canada could consider targeting increased support for these functions, and having its trade negotiators urge more formal participation by these groups in WTO negotiating meetings.

Formal linkages of the WTO with multilateral environmental and health institutions has been critiqued as potentially hampering trade policy with social and environmental policies. These critiques ignore three important facts. First, trade has both positive and negative environmental and health externalities that must be accounted for in negotiating trade agreements. Second, the formal dispute mechanisms and enforcement measures give more implementation authority to the WTO at the possible expense of other multilateral agreements. Third, national democratic governments are continually balancing economic goals against social, health and environmental goals, in Cabinet, in legislatures and in elections. Given the arguments around GPHs for Health made in this section, there is no warrantable reason why such balancing should not be present in international fora.
There is also a widely recognized need to increase the participation of civil society groups in trade policy discussions, especially with respect to the potential negative health externalities arising from trade liberalization. The participation of civil society groups with governments and multilateral institutions where global health interventions and trade policies are being discussed is subsumed under two new concepts: global health governance and public-private partnerships. The WHO’s work on the FCTC, for example, includes both government and civil society representatives. Fidler (2002a) offers another compelling example:

A body known as the "Green Light Committee," consisting of representatives from WHO, two national governments (Peru and the United States), and civil society groups (Royal Netherlands TB Association, Harvard Medical School, Medecins Sans Frontieres), makes decisions about access to the concessionally priced tuberculosis drugs. The new institution, procedures, and rules attempt to make sure that cheap drugs are both available to treat tuberculosis and used properly to prevent the development of drug resistance. The institution [another example of a GPG for health], procedures and rules are not, however, created through a treaty, rule of CIL [customary international law], or general principle of law. Further, civil society participation seems as critical to the creation and implementation of the new regime as the involvement of WHO and representatives from states. The contribution of this and other novel governance regimes to the production of GPGH [GPG for health] deserves close attention in the future, particularly in connection with their impact on public health in developing countries (p.33).

Summary and conclusion

The concept of GPGs for health identifies areas where Canada needs to ensure it is fulfilling, or surpassing, existing multilateral commitments, specifically key multilateral environmental agreements (Kyoto Protocol, Biodiversity Convention, Cartagena Protocol) and key human rights and other social accords (Universal Declaration on Human Rights). It identifies new as well as existing areas where Canada’s contributions to intermediary GPGs should be increased (a Global Health Research fund, health and trade research activities at the WHO and PAHO, similar ongoing national research involving civil society groups as well as governments and academics, new framework conventions on public health issues such as tobacco control, supports to developing country participation in WTO and offsets for WTO Agreement implementation costs). It highlights the need to integrate health more fully and centrally in trade negotiations to avoid past problems (e.g. tobacco control) and weakening of any future framework convention treaties modeled on the FCTC. This should extend to consideration of revisions to existing trade
agreements that may compromise domestic public health measures (e.g. tobacco control vs. NAFTA Chapter 11 and TRIPS) or interfere with public health measures in other countries (e.g. SPS and GATT XX(b)); and to less inconsistency in its foreign policy practices (e.g. increased tobacco control domestically, increased tobacco exports globally). It infers a responsibility to increase funding for new global health initiatives, such as the GFATM and the recommendations of the Commission on Macroeconomics and Health, aimed at increasing health interventions and infrastructures in poorer countries. It also underscores the need for more concerted action on the creation of global financing mechanisms able to fund the required infrastructures for GPGs in developing countries, and the protection of GPGs themselves:

To the extent that a clearer focus on global public goods means more expenditures, resources could be freed by reducing perverse fiscal incentives, or incentives that encourage public bads. ... [A] worldwide tax on carbon emissions [for example] would in 2020 yield some $750 billion in revenue, or 1.3% of that year’s gross world product (Kaul, Grunberg and Stern, 1999; p.497).

Finally, GPGs emphasizes that Canada undertakes these efforts not simply because of its moral or international legal/normative commitments. A GPG for health, while disproportionately or more immediately benefiting those less healthy or lacking access to key health determining conditions and services, increases Canadians’ security in their personal health by reducing the risk of infectious disease and globally destabilizing regional conflicts, and improving the global economic system for more sustainable and equitable growth.
Section 4 HEALTH AS A COMMODITY

Our international trade commitments are yet another facet of Canadian foreign policy as it relates to health. Canada is party to a number of trade agreements and negotiations which have an impact on health. That impact can be through international treaties on trade in merchanides (pharmaceutical products and medical equipment), on trade in health services such as medical and nursing services or treaties on foreign investment. Public health can be affected by trade agreements in a variety of ways (Correa, 2000). This section only touches upon some of the potential areas of impact.

This section of the report first examines the economic interests of Canada in the health sector. How much health products and services are exported and imported? How many health professionals cross the border to offer their services (temporarily or not)? How much foreign investment is there in the health services sector? Once the landscape of our economic interests is surveyed, we review the various elements of Canadian trade policy relevant to health. What are the existing commitments Canada has taken? What positions has the Government of Canada taken in current trade negotiations, during trade disputes or trade promotion activities?

Overview of Canadian trade interests

*Trade in goods*

International trade in the health sector involves mostly pharmaceutical products and medical equipment. As we can see in Tables 3, 4 and 5, Canada has a large trade deficit in both sectors. The following section will highlight the main characteristics of each industry, to help understand the reasons underlining this trade deficit.

The Canadian pharmaceutical industry employs over 30,000 employees and generated $5 billion in 1998, 30% of which was exported. It thus represents one percent of total manufacturing activity in Canada and 1.6% of manufacturing employment (Statistic Canada, Industry Canada, 2001, 2000b). Its export orientation increased in the last decade, as exports stood at only 7% of production in 1990. Our imports increased at a similar rate, therefore our trade deficit remains large. The sector is increasingly research-intensive with investment in research and development (R&D) of $605 million in 1998, representing 9% of industrial R&D in Canada (Statistics
In 1989, pharmaceutical research represented 6.9% of all industrial research ($255 million).

We can distinguish two main domestic providers of pharmaceutical products in Canada: the brand-name pharmaceutical companies and the manufacturers of generic pharmaceutical products. The former possess the intellectual property rights, the twenty-year patents, on medicinal drugs. These brand-name pharmaceutical companies form the largest group with over 20,000 employees and 87% of the total domestic market (Vandergrift and Kavanos, 1997, p.144). The majority of them are foreign-owned subsidiaries, especially the large firms. Hence, less than 40% of the members of the national association of Canada’s research-based pharmaceutical companies are Canadian companies. The transnational nature of the ownership of pharmaceutical companies is considered an important factor to explain our historic trade deficit in this area. "The major firms are headquartered in the US, the UK, Sweden, Germany, France and Switzerland. Most of the production and R&D capabilities of the key companies remain in the home country. Other markets, including Canada, have been served by subsidiaries of the multinational firms or by exports. Countries that are home to major companies typically run significant trade surpluses and other developed country markets run deficits" (Industry Canada, 2001 (p.2 of 16). Indeed, the United States and Europe are the source of the vast majority of our imports. Active ingredients needed to produce the medicines constitute a large part of these imports.

The second group of pharmaceutical companies, the generic drugs companies, employs 5600 people in Canada, with revenues of $1.1 billion in 1998 (Industry Canada, 2000b, CDMA, 1999). These firms produce drugs whose patents have expired. Between 1969 and 1993, the compulsory licensing regime allowed generic companies to produce and sell drugs still under patent, if they paid a royalty fee to the patent-holder (fee generally set at 4% of sales). This regime was eliminated in 1993 as part of the harmonization of intellectual property rights created by trade agreements such NAFTA and the negotiations of the WTO Agreement on Intellectual Property (TRIPS). To balance the monopoly power created by the new regime, powers to control drug

27 A growing industry is the bio-pharmaceutical industry which is in formative stages in Canada and worldwide. These companies are very active on the biotechnology research front, but few products have been available on the market yet. It is estimated that that 6700 people work in this industry (Industry Canada, 2001, 2000b).
prices were granted to the Patented Medicine Prices Review Board (PMPRB). This was the strategy adopted by the Canadian government to deal with the "pharmaceutical problem", i.e., how to achieve the contradictory tasks of controlling rising health care costs while having an industrial policy promoting the domestic pharmaceutical sector (Vandergrift and Kanavos, 1997). Indeed, the Canadian government hoped that the increased level of IP protection would promote Canadian innovative investments, in this case R&D in the domestic pharmaceutical industry.

Another factor which has an impact on this Canadian trade deficit is the restrictions on the export of generic drugs. Canadian law does not allow generic drug manufacturers to export medicines which are under patent in Canada to countries where there is no patent protection or where the patents have expired earlier. A report commissioned by Industry Canada found that the prospects for increasing Canadian exports in pharmaceutical products were better in the generic and over-the-counter drug segments than in the brand name prescription segment of the industry (Ference Weicker & Company, 1996).

The generic producers recommend to allow generic products to be exporter prior to the expiration of the Canadian patents in order to take advantage of the growing opportunities in that industry segment. They assert that the TRIPs permit such an exception and that they should be allowed to produce and sell in countries without the intellectual property protection provided in Canada (CDMA Website). The Canadian view is that the TRIPS does not allow such export exception, as drugs produced under compulsory licensing have to be targeted primarily to the domestic market, not foreign markets (Interview with Canadian official, see Article 31 (f) of the TRIPS). This rule is currently under discussions at the WTO regarding the access to generic medicines for countries without manufacturing capacity.

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28 If Canadian patents are expired or do not apply, the generic drugs can be exported without being licensed by the Canadian regulatory agency (Correspondence between Joel Lexchin and Health Canada, July 10, 1997).
Table 3

Canadian Trade in Pharmaceutical Products  (in millions of Canadian dollars)

<table>
<thead>
<tr>
<th></th>
<th>Exports</th>
<th>Imports</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1983</td>
<td>144</td>
<td>510</td>
<td>366</td>
</tr>
<tr>
<td>1989</td>
<td>293</td>
<td>946</td>
<td>653</td>
</tr>
<tr>
<td>1995</td>
<td>815</td>
<td>2 037</td>
<td>1 222</td>
</tr>
<tr>
<td>2000</td>
<td>1 785</td>
<td>5 144</td>
<td>3 359</td>
</tr>
</tbody>
</table>

Source: Strategis Canada, Trade Data Online

Table 4

Pharmaceuticals Import Penetration in Canadian Market

<table>
<thead>
<tr>
<th>Year</th>
<th>Imports as a % of Domestic market</th>
</tr>
</thead>
<tbody>
<tr>
<td>1983</td>
<td>18.0</td>
</tr>
<tr>
<td>1987</td>
<td>20.2</td>
</tr>
<tr>
<td>1988</td>
<td>23.9</td>
</tr>
<tr>
<td>1993</td>
<td>34.4</td>
</tr>
<tr>
<td>1994</td>
<td>39.2</td>
</tr>
<tr>
<td>2000</td>
<td>75.5</td>
</tr>
</tbody>
</table>

Source: Lexchin, 2001

In contrast to the pharmaceutical industry, the medical equipment sector in Canada is mostly composed of small Canadian-owned firms. The sector employs 18,000 Canadians and generated $2.7 billion in 1998. Half of these products were exported to three main markets: the United States, Europe and Japan. Canada's trade deficit of $3 billion in this sector is slightly smaller than the trade deficit in pharmaceutical products. One of the main trade issues in this sector is technical regulations in other jurisdictions, i.e., approval of medical devices from national regulatory agencies such as the US Food and Drug Agency.
Table 5

Canadian Trade in Medical Equipment
(in millions of Canadian dollars)

<table>
<thead>
<tr>
<th>Year</th>
<th>Exports</th>
<th>Imports</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>1,106</td>
<td>2,816</td>
<td>1,710</td>
</tr>
<tr>
<td>1998</td>
<td>1,326</td>
<td>3,286</td>
<td>1,960</td>
</tr>
<tr>
<td>1999</td>
<td>1,454</td>
<td>3,713</td>
<td>2,259</td>
</tr>
<tr>
<td>2000</td>
<td>1,333</td>
<td>3,879</td>
<td>2,546</td>
</tr>
<tr>
<td>2001</td>
<td>1,401</td>
<td>4,429</td>
<td>3028</td>
</tr>
</tbody>
</table>

Source: Strategis Canada, Trade Data Online

Trade in services

Trade in health services is still a relatively limited phenomenon. Statistical information is still scarce for most countries, including Canada. Most empirical evidence available is based on US statistics or estimates, which also suggest that international trade in medical and health services is still modest, US exports are estimated to be less than 2/1000 of total US health care spending (WTO, 1998).

In 1995, the members of the World Trade Organisation adopted the General Agreement on Trade in Services (GATS), which was the first multilateral trade agreement on services. Under this agreement, trade in services can take place under four modes. In mode 1, there is a cross-border provision of the service; information and communications technologies can allow the supply of the services without physical proximity. Telemedicine services and online health information are examples of such cross-border provision. In mode 2, the consumer moves across the border and receive the service abroad. For instance, a Canadian patient might travel to the United States to undergo surgery, or a Canadian tourist would receive emergency care during a trip in Europe. In mode 3, a foreign-owned facility can supply the service. An American-owned clinic providing health services in Argentina would be of what is often called "commercial presence". Finally, trade in health services can take place through the temporary cross-border movement of suppliers such as the doctors and nurses.
Mode 1 Cross-border trade: The potential of telehealth

Telehealth includes a variety of health services using advanced communications technologies, most of these supplied within one country, some across borders. The problem of defining what is telehealth led to "considerable confusion over the market figures which have been published over the last few years predicting or estimating the size of the telehealth and telemedicine markets, both domestically and world-wide" (Picot and Cradduck, 2000, vol.1).

This report from Industry Canada stressed that the Canadian telehealth industry is focused on the domestic market, with only one of the companies surveyed having significant operations outside Canada (Picot and Cradduck, 2000). Their findings are congruent with the WHO and WTO evaluation that, to date, telemedicine has been mostly used within individual countries, especially for remote regions within one country (WTO, 1998, Adams and Kinnon, 1997). Indeed, there are several jurisdictional obstacles to cross-border provision of telehealth such as recognition of professional credentials and malpractice insurance coverage.

Nevertheless, telehealth has been identified by Trade Team Canada as a priority sector in the health industries, an infant sector of $330 million with "the potential for dramatic growth both in Canada and international markets" (Industry Canada, 2000b). The United States, the EU (UK, France, Germany) and Japan have been targeted for government efforts to support the industry's international activities.

Mode 2 Consumption abroad: Health tourism

This type of international trade is health services is probably more important than the cross-border trade. However, for the moment, the greater part of this "trade" consists of foreigners becoming sick and needing care during their visit abroad, not of patients travelling expressly to receive treatment (WTO, 1998). In the United States, this type of export amounted to US$1.2 billion in 1998 (USITC, 2000).

In Canada, it has been estimated that such transactions are quite limited (Canadian Institute for Health Information and Statistics Canada, 2000). For instance, "fewer than 0.1% of Canadians
reported being treated in the U.S. in the past year in the 1998/99 National Population Health Survey." Statistics Canada's balance of payment figures give us some indications about Canadians receiving health and social services while travelling abroad, to the amount of $235 million in 1999 (see Table 6).

Table 6

<table>
<thead>
<tr>
<th>Year</th>
<th>Export (in millions of Canadian dollars)</th>
<th>Import (in millions of Canadian dollars)</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>67.7</td>
<td>185.9</td>
<td>118.2</td>
</tr>
<tr>
<td>1993</td>
<td>66.3</td>
<td>131.7</td>
<td>65.4</td>
</tr>
<tr>
<td>1994</td>
<td>69.8</td>
<td>98</td>
<td>28.2</td>
</tr>
<tr>
<td>1995</td>
<td>85.7</td>
<td>183.6</td>
<td>97.9</td>
</tr>
<tr>
<td>1996</td>
<td>86.6</td>
<td>198.3</td>
<td>111.7</td>
</tr>
<tr>
<td>1997</td>
<td>87.8</td>
<td>225.3</td>
<td>137.5</td>
</tr>
<tr>
<td>1998</td>
<td>95.0</td>
<td>232.4</td>
<td>137.4</td>
</tr>
<tr>
<td>1999</td>
<td>95.2</td>
<td>235</td>
<td>139.8</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, CANSIM II Series V1903914

Mode 3 Commercial presence: Foreign investment in health facilities

Debates about foreign investment in health services are inevitably very controversial, as they are linked to the debate about privatization of the public aspect of the health care system. Indeed, "as a mode of health services supply and trade liberalization, foreign commercial presence fits squarely in the debate about public/private health care in health policy. Not surprisingly, arguments for both privatization and foreign commercial presence are similar (i.e., better cost control, improved efficiency and quality of care and services)" (Velinga, 2001, p.175).29

The debates about privatization are linked to the debates on liberalization (allowing foreign providers) as both are related to the broader issue of the commodification of a service vs. its

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29 The author also highlights that there is no clear empirical evidence to support these arguments for privatization or liberalization.
provision outside market mechanisms, as a public service. Some public officials stated that these debates are not related: "The concern (...) is creeping privatization of those services and changes in policy in respect of those services that don't have anything to do with trade. They are decisions that are made in other policy fora, for other reasons" (Don Stephenson SCFAIT Hearings Transcripts, January 30, 2002). Even though the debate about allowing private providers, for-profit providers takes place in a different forum than the debate about allowing foreign providers, they are linked in several ways. The second paper prepared for the Commission on the impact of trade agreements on Canadian health care examines such links between privatisation and removing barriers to entry for foreign firms.

We have not found statistical information on this mode of supply or publications making an inventory of the foreign-owned health services providers based in Canada (such as in health insurance, in long-term care facilities, rehabilitation clinics, or hospital management services). However, the research team was made aware of one example of foreign-owned Canadian health facility, in the ownership of long-term care facilities by Advocat Inc, an American firm owning or operating assisted living facilities in four provinces. There are some examples of Canadian-owned health care facilities abroad. Extendicare and CPL-REIT are two Canadian companies who own and manage long-term care facilities in the United States. MDS Inc. and DynaCare Inc. are the two largest Canadian laboratory services companies with facilities and joint-ventures in the United States.\textsuperscript{30}

Trade in health services though commercial presence is more common in the United States where foreign service suppliers provided US$4.7 billion of services in 1997; European firms accounted for 70\% of these transactions. Therefore, the US has a large trade deficit in health services, as US exports of health services through this mode are relatively modest. In 1997, sales of US-owned health facilities abroad amounted to US$351 millions, 94\% of which came from Europe and the rest from Latin America (USITC, 2000).

\textsuperscript{30} Source: Annual report of firms.
Mode 4 Health professionals’ migration: Brain drain?
The migration of Canadian health professionals to the United States poses a major policy challenge. The problem of the shortage of health professionals is a pressing one for many regions of Canada. Therefore, the impact of the migration of these service providers on our healthcare systems is severe. From a trade perspective, only temporary movement of personnel is considered to be a Canadian export of health services. Permanent emigration of nurses and physicians is not considered as international trade per se. In a study of migration knowledge workers to and from Canada, Zhao et al. found that health professionals are the most likely to permanently emigrate to the United States and are increasingly doing so (Zhao et al. 2000, p.17-18). The number of physicians emigrating to the US grew from an average of 150 a year in the late 1980s to 450 a year in 1996 and 1997. For nurses, it increased from 330 a year to 825 nurses leaving Canada in 1996 and 1997. This emigration is not compensated by the numbers of immigrants, as only 270 physicians and 350 nurses came to Canada in 1997.

Another important and controversial issue concerning the migration (whether on a temporary or permanent basis) of health professionals is the impact of the north-south migration, i.e., physicians and nurses from developing countries moving to industrial ones. Indeed, "trade in health services via movement of persons mainly consists of exports of health providers from developing to developed countries and between developing countries in certain parts of the world. An estimated 56 per cent of all migrating physicians flow from developing countries to developed countries while the latter receive only 11 per cent of all migrating physicians. The emigration percentage is even higher for nurses" (Chanda, 2001, p.13).  

31 Canada participates to this brain drain by the active recruitment of physicians and nurses from developing countries by Canadian provincial governments. For instance, the government of Alberta has done active recruitment of more than forty physicians from South Africa to fill the numerous vacancies in the rural communities in this province (Bundred and Levitt, 2000). The problem of the brain drain in developing countries is not unique to the health sector, but given the public service dimension of health services and the weakness of many developing countries' health infrastructure, it is

31 "In South Africa for instance, an estimated 10,000 health professionals emigrated from the country during the 1989-97 period. According to information from medical schools, between one-third to one-half of the graduating class each year emigrates abroad, temporarily or permanently, with the majority going to the US and the UK (Chanda, 2001, p.24)
particularly problematic in this sector (Chandra, 2001). Hence, strong reservations have been expressed against such practices of active recruitment (The Lancet, 2000, Royal College of Physicians and Surgeons of Canada, 2001). The British Department of Health has therefore emitted guidelines on international recruitment to the effect that developing countries should not be targeted for recruitment. To our knowledge, the Canadian government has not announced its position on this matter.

We should note that for temporary movement of personnel, reliable statistics are more difficult to find. Based on tax filing information, we learn that 1060 hospital workers left Canada in 1996 (Zhao et al., 2000, Table 5). However, Zhao et al. do not deem the issuance of NAFTA visas as a reliable source of information on Canadians entry into the United States, as these figures often include multiple entries and renewals of visas by the same individuals, as well as very short stays.

After this brief overview of what we know of the recent trade trends, how can we characterize the economic interests of Canada in the health sector? One could say that Canada's current export interests are moderate as for health products and weak in health services. Canada is not a major global actor in the supply of pharmaceuticals and medical equipment and these sectors do not constitute a large part of Canadian exports. Nevertheless, the pharmaceutical industry has received sustained attention from the federal and provincial industrial policies, given their research-intensive nature and the strategy to develop a more knowledge-based economy.

**Review of Canadian trade policy**

The remainder of this section reviews the international commitments taken by Canada at the multilateral and regional level in trade treaties on services and health-related products such as medicines. It will also examine Canadian positions in current trade negotiations in regional and multilateral forums focussing on the issue of the impact of the WTO Agreement on Intellectual Property (TRIPs) on access to medicine.
Current trade Canadian commitments and positions in health services

In the last decade, a new type of trade agreement with important implications for domestic public policies, including health policy, came to the international scene: i.e., agreements on trade in services. Canada is party to two major agreements on trade in services: the North American Free Trade Agreement (NAFTA) and the General Agreement on Trade in Services (GATS) at the WTO. The intention of the Canadian government in both negotiations was to exclude the health services sector from the rules of the trade agreements. However, there are uncertainties regarding the impact of these two agreements on the Canadian health system, which are examined in the second paper on health and globalisation prepared by our research team.

In general, industrialized countries did not make substantial sectoral commitments to open their health services sector to foreign private competitors. This probably reflects most higher-income countries' policy preferences to consider health care as a public service, not a tradable commodity. Indeed, most of them have a public health care system with universal insurance coverage and largely state financing (Velinga, 2001). Overall, the commitments taken by WTO members on services in the Uruguay Round were mostly "stand-still" commitments, i.e., members did not open new services sectors to foreign competition, they mostly committed to the status quo. However, the GATS mandates further liberalization and negotiations that began in 2000. In 2001, the Canadian government announced its initial positions for these new GATS negotiations. The negotiating proposals state that one of Canada's main objectives in this process is "to preserve the ability of Canada and Canadians to maintain or establish regulations, subsidies, administrative practices or other measures in sectors such as health, public education and social services" (DFAIT, 2001, p.2).

Opening health services markets abroad is not an objective for Canada in GATS negotiations either, as there is no request from Canada to other WTO members to make commitments in this sector. Technically, nothing prohibits a member from requesting others to open their market to its exports in one particular market, while asserting its right to protect the same sector from
However, in the political dynamics of trade negotiations, a position to protect certain sectors from foreign competition can be weakened by making such requests of others. Therefore, Canada has preferred not to request any commitments. On the other hand, the Trade Team Canada's International Business Strategy identifies telehealth as a priority sector for promotion in the next years (Industry Canada, 2000). It has been argued that this export promotion strategy conflicts with the Canadian trade policy to exclude the health services sector from its commitments (Sanger, 2001). The interactions between export promotion and trade policy as expressed in treaties and their negotiations have not been carefully examined in the literature.

In addition to its NAFTA and WTO commitments, Canada is currently negotiating a free trade agreement with all the countries of the Western Hemisphere (except Cuba). The Free Trade Area of the Americas (FTAA) negotiations cover a wide range of issues, including sectors such as services and intellectual property that have direct and indirect impacts on health. The objective is adopt an agreement in 2005 which will remove all barriers to trade and investment in the hemisphere. Canada has not yet made formal proposals to the negotiating groups on services and on intellectual property but has expressed preliminary positions on these issues. In health services, the Canadian position in the FTAA negotiations is similar to the one expressed in the GATS negotiations, aiming at preserving the ability to adopt or maintain regulations and administrative practices in sectors such as health and social services. Services supplied in the exercise of governmental authority should be clearly excluded, and members should be free to exclude certain measures from the commitments on most-favoured-nation treatment, national treatment and market access (http:/www.dfait-maeci.gc.ca/tna-nac/S-P&P-e.asp, July 3, 2001).

Current trade Canadian commitments and positions regarding the pharmaceutical sector

Intellectual property rights are at the forefront of policy debates in the pharmaceutical sector. In recent years, there has been an international controversy regarding the impact of international

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32 As a DFAIT official explained: "Even if we were to decide to ask for the elimination of barriers to our access in other countries in education, for example, the structure of the GATS makes it absolutely possible for us to refuse access to our own market." (Don Stephenson, SCFAIT Hearing Transcripts, January 30, 2002) Canadian institutions have been very active in exporting their services abroad, but do not face important barriers in these activities. Therefore, they do not see GATS commitments as necessary for their access to foreign markets.
trade agreements on intellectual property on access to essential medicines. Like all WTO members, Canada is a party to the Agreement on Trade-Related Aspects of Intellectual Property (TRIPS). This agreement provides a 20-year protection for patent-holders, representing a major change for developing countries as many of them had no protection for patents before. Developing countries were granted a minimum of five years to implement the new agreement, but several countries are concerned about the impact of these protections on the price and accessibility of pharmaceuticals products. In several national settings such as South Africa, Brazil and Thailand, the controversy was focused on the capacity of developing countries to access affordable drugs to face the HIV/AIDS pandemic.

Within the international legal framework set by TRIPS, national governments have the right to override patents and issue compulsory licenses to produce cheap medicines, provided certain conditions are met. When facing an emergency situation, these restrictions are even fewer. Despite these provisions, two major problems confront developing countries in this matter. First, national governments face strong political, economic and legal pressures from pharmaceutical firms and industrialized country governments not to avail themselves with the right to compulsory licensing. For instance, in South Africa, multinational firms sued the government over a legislative proposal allowing compulsory licensing and parallel importing. Moreover, the American government imposed trade sanctions to convince the South African government to withdraw this same bill. The US Trade Representative alleged that the legislation was violating international trade agreements on intellectual property (Bond, 1999, Larkin, 1999). The political and economic pressures from the US government were withdrawn in the fall of 1999, after domestic and international campaigns from different non-governmental groups brought light upon the fact that South Africa's actions were in compliance with its international obligations and the government was taking legitimate steps to confront a health emergency crisis. The legal procedure by 39 pharmaceutical firms against the South African government was only withdrawn in the spring of 2001, after a large international campaign.

The second problem linked to the TRIPS agreement is the lack of access to essential medicine for the developing countries that do not have the industrial and technological capacity to produce medicines in their country and have no choice but to import them. Only three countries are
Currently producing affordable generic drugs for AIDS: India, Brazil and Thailand. The provisions of the TRIPs on compulsory licensing specify that production under such licenses must be "authorized predominantly for the supply of the domestic market" (article 31 (f) of TRIPS). This clause would prevent Brazil or India from exporting sufficient quantity of medicines for the millions of AIDS patients in Africa.

What was Canada's position during these important debates? In general, the Canadian position regarding intellectual property rights is that they should represent "a balance between the need to provide incentives to spur innovation and the benefits derived by society to have maximum access to new creations" (DFAIT, 2001b). But how did his approach to balance economic interests of patent holders and public health objectives materialise on the international stage? During the controversy around the South African legislation, Canada did not take a position, i.e., the Canadian government did not make official statements supporting the American pressures or affirming the right of the South African government to adopt the measures proposed in the legislation. (The only exception was a statement by CIDA Minister Maria Minna in July 2000 during a conference on AIDS taking place in Durban, South Africa. She declared that "Canada would support the suspension of international drug patent agreements to make generic drug more accessible to developing countries, especially in cases of emergencies" (Reuters, 2000). This position was never endorsed by the Government and was later dismissed as a misquotation of the Minister).

To put a brake to the type of harassment South Africa and others had been subjected to, developing countries proposed that the WTO Ministerial meeting in Doha in November 2001 adopt a declaration on intellectual property. The document would affirm that nothing in the TRIPs prevents WTO members from adopting measures to protect public health, hence clearly asserting the right to issue compulsory licensing and to use other means to decrease drug prices such as parallel importing.

During the preparations to the Doha ministerial meeting, Canada opposed the proposal from developing countries stating that nothing in the TRIPS agreements prevents the adoption of measures to protect public health. Canada supported a declaration proposed by the United
States, Switzerland, Japan and Australia that the current provisions were sufficiently flexible to address public health crises such as HIV/AIDS and other pandemics. As stated in the DFAIT's Intellectual Property Rights Information Paper of August 2001, "the TRIPS Agreement provides individual members with the necessary flexibility to adopt measures in order to protect sectors of vital importance in their countries, such as public health."33 The Minister of International Trade, Pierre Pettigrew, reaffirmed this position in October 2001 in parliamentary hearings, though with more nuances. "Our position is that the TRIPS agreement is probably acceptable, probably good, as is. Indeed, with the built-in flexibilities in the existing agreement, we will be able to find room to accommodate the needs of developing countries" (SCFAIT, Hearing Transcripts, October 24, 2001). This position did not recognize the problems developing countries were facing when using these flexibilities, as foreign governments and companies challenge their use.

During the ministerial meeting in Doha, the developing countries convincingly argued for their version of the declaration on TRIPs and public health. In the end, the declaration states that "the TRIPS agreement does not and should not prevent Members from taking measures to protect public health" and the Government of Canada now supports this declaration (Declaration available at http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm). Indeed, an official from the Department of Foreign Affairs and International Trade (DFAIT) explained the need for this public statement during a parliamentary hearing. "The declaration was very important because although those provisions were in the TRIPS agreement before, they were not clear, and a number of cases had taken place, most notably in South Africa, where there was some question as to whether HIV-AIDS would qualify or not. The declaration clearly confirms that a disease of that sort would qualify as a situation of national emergency, and therefore action could be taken without the member country having fear of dispute-settlement proceedings. That was a very important clarification" (Catherine Dickson, SCFAIT Hearings Transcripts, December 11, 2001).

33 The document also stressed that patents are only one part of the problem of access to medicine. "The provision of drugs and therapies is a complex question involving patent rights, the establishment of systems to deliver and monitor drug usage, cost and alternative mechanisms to finance drug purchases by developing countries. The majority of drugs on the World Health Organization’s (WHO) List of Essential Drugs are not covered by patents. These include many vaccines as well as drugs for which the patents have expired" DFAIT, 2001 - WTO
Why did Canada first oppose the declaration put forward by developing countries? The position of Canada at the WTO has to be understood in the context of the Quad's (US, EU, Japan, Canada) view on intellectual property. The proposal from the developing countries was seen as a threat to the current TRIPs agreement, as creating broad exceptions to the WTO rules. As characterized by a Canadian official, the United States is the most vocal defendant of strong IP protection and the EU more willing to loosen the grip of the agreement. Despite these differences, there is a convergence of views and interests among Quad countries to ensure the implementation of the TRIPS Agreement. Canada aligned itself with the Quad proposal, as it was perceived to be in our interests to preserve strong IP protection for pharmaceutical products.

Even though they represent a relatively small part of the Canadian economy, the contribution of the Canadian brand-name pharmaceutical companies to the knowledge economy is greatly valued. The government considered the declaration as a potential threat to the interests of these firms. Indeed, "concerns were expressed about exhaustion of patents, and particularly, about "parallel importing" and the fear of seepage into northern markets, if cheaper drugs were permitted in the south" (Foster, 2002, p.14.) Brand-name pharmaceutical firms have been very active and mobilised in promoting their interests with the federal government and therefore, Canadians politicians and bureaucrats are very much aware of their policy preferences. An additional piece in the puzzle of the political economy of Canadian IP policy on the international stage is that the vast majority of these companies are located in the province of Quebec, which gives them important additional political clout, given Quebec-Ottawa relations (McGregor, 2001, 2002).


34 An interviewee suggested that the reason for the different approach between these two important producers of pharmaceutical lies in the isolation the European Commission, which represents the EU in Geneva, has vis-à-vis the pharmaceutical firms in their region. German companies may complain to the German government, but the pressures may not be transmitted to the second-level of the policymaking structure.

35 "I would say that Canada was not ultimately one of the big players on this issue, at least not in economic terms, but we did play an important role in finding the compromise leading up to Doha and at Doha. Much of the language that was adopted in the ministerial declaration on TRIPS and health was proposed by Canada, but ultimately it came down to a compromise between the United States and Brazil. The United States was representing, in effect, the innovative industries, the companies that invest in research and development to produce new pharmaceutical products. Brazil and certain others were representing more of an interest in the generic drug manufacturing industry." (Don Stephenson, SCFAIT, Transcript Hearings, December 11, 2001).
The second problem many developing countries faced with the TRIPS is the lack of manufacturing capacity to prevail themselves of the exceptions allowing compulsory licensing. There are currently discussions on this issue at the WTO. Indeed, the Doha Ministerial Declaration mandated the WTO TRIPS Council to find a solution to the problem of countries without production capacity at the TRIPS Council before the end of 2002. The EU made the first proposal on March 5, 2002 focusing on two possible options:

- an amendment to the relevant Article of the TRIPS agreement (31f) so that the medicines can be produced elsewhere and exported to the country in need or
- that Article 30 of the TRIPS agreement be interpreted in such a way as to allow medicines to be produced elsewhere for export to the country in need.

The United States proposed a moratorium on trade disputes related to IP and drugs. The Canadian government did not express support for either of these proposals nor has it put forward any proposal on this issue at the TRIPs Council. Interviewees stressed that, to receive Canadian support, the solution which will be agreed among the members must be clear on which countries are deemed to have no production facilities, which diseases will be covered by the exception and what provisions will be taken to prevent "leakage" of the cheap drugs into Northern markets.

Another international trade forum where discussions on intellectual property take place is the FTAA negotiations. The Canadian negotiation objective on intellectual property is "to maintain and support the improvements achieved within the WTO while also pursuing areas of specific interests to Canada… and to ensure that ongoing discussions within the FTAA Negotiating Group on Intellectual Property leave open the possibility of further developing intellectual property rules in the Hemisphere, for example, as they relate to new technologies." (http://www.dfait-maeci.gc.ca/tna-nac/ip-summary-e.asp, February 26, 2001). Hence, Canada's goal is not to include stronger protection for IP right-holders in the FTAA, but "to ensure that the current international IP rules are fully implemented, rather than to seek an extension on existing IP rights protection" (http://www.dfait-meaci.gc.ca/tna-nac/IP-P&P-e.asp, July 3, 2001).

On intellectual property, the Canadian government has adopted a policy which prioritizes the implementation of the WTO's agreement on intellectual property (TRIPs) over other policy
objectives. The current official position that the TRIPs represents a balance between commercial and public health interests has been challenged by developing countries’ representatives, scholars, policy analysts and activists from all parts of the world. In light of the importance of access to medicine to treat diseases such as HIV-AIDS and Canada's international commitments to health as human right, this position has to be reviewed. Proposals to that effect are made in the concluding sector of this paper.
Section 5 CONCLUSIONS: CANADIAN VALUES, HEALTH AND FOREIGN POLICY

We know from earlier research on attitudes on health care that Canadians hold very strong values of equality and access. This paper aimed to evaluate how these values are projected at the international level. In order to draw a portrait of Canadian foreign policy toward health, we examined Canada's commitments, activities and positions in a variety of international fora. We identified some of the strengths and weaknesses of our policy, in terms of the coherence of its various parts. This final section brings together our recommendations on how to address these deficiencies. We propose procedural and substantial changes to our Canadian foreign policy on health allowing for a better reflection of our values.

Apart from the value-based realignment of Canadian foreign policy to give greater precedence to health, there are several practical and self-interested reasons. The two we have emphasized throughout this paper are the importance of stopping the development and trans-border spread of treatment-resistant infectious disease, and reducing the burden of disease of the world’s poor, which increasingly undermines economic development, state sustainability and regional/global security. This requires, inter alia, increased Canadian contributions in ODA and to global public goods that lead to the improvement of the health infrastructures and disease prevention activities of poorer nations.

A recent conference hosted by RAND and the Nuffield Trust brought several of these concerns together in an argument for placing "health" as the central element, or "currency," in 21st century foreign policy (Ditchley Foundation, 2002). The conference noted that the end of the Cold War brought with it a demise of any globally organizing foreign policy (except, perhaps, that of control over scarce and valued natural resources). Health as a central driving force in foreign policy – with all its requisites in terms of enhanced ODA and GPG for health investments – not only reduces risk of global disease transmission and insecurity. It also spurs economic development within poorer nations (WHO, 2001) which, to the degree it is environmentally sustainable, further decreases disease transmission and security risks. We are aware that many of our recommendations call for increased Canadian allocations for global health programs in health infrastructure development and research. This may seem a difficult option to a
Commission faced with difficult funding choices facing Canada’s domestic health care system. We believe such expenditures are defensible on human rights, as well as domestic public health, grounds. They are also in Canada’s best long-term economic interests.

One of the key deficiencies of our foreign policy related to health is the lack of an overarching human rights framework, which would both reflect Canadians' values of equity and access to health care and our existing international human rights' commitments. This final section will propose a number of recommendations on how to address this weakness.

**Health a human right as overarching framework**

Canadians cherish the values of equity and access embedded in our health care system and the implicit principle of the right to health underlining the system. Therefore, we suggest that in order to achieve a foreign policy projecting our values abroad, we need to include an explicit strategy of championing health as a human right on the international stage. Such a strategy includes several elements:

Canada should explicitly recognise the primacy of human rights law over other elements of international law, including international trade and investment law. Canada should work to develop an international legal regime to settle possible conflicts between human rights law and other bodies of international law. It should be outside the WTO, within the UN system, comparable to or part of the International Court of Justice.

Canada should undertake a full human rights assessment of any trade and investment agreements before finalization, and negotiating positions taken on behalf of Canada embody our human rights commitments. Canada should abandon or derogate from such trade and investment agreements that conflict with or undermine our human rights obligations. For instance, on intellectual property protection, this would translate into changing our strategy and adopting a more flexible approach and a willingness to consider a reduction of the level of protection offered to pharmaceutical products, including amending the WTO Agreement on Intellectual Property (TRIPs).
International support for human right bodies

Canada should strengthen its support for the main relevant international treaty body: the Committee on Economic Social and Cultural Rights, to which we report every five years. This would involve increased financial support for the committee, the strengthening of Canada’s reports related to the implementation of the right to health, and more effective implementation of the judgments of the committee. Canada should strongly support the creation of a protocol to the Covenant on Economic, Social and Cultural Rights enabling a complaint mechanism which would include individual complaints.

Canada should also strengthen its support for the main relevant international customary law body: the UN Commission on Human Rights. It should increase its support for work on human rights and health, as well as other constituents of health (housing, food, etc.), and support such initiatives as the Commission's resolution on access to medication in the context of pandemics such as HIV/AIDS.

Domestic recognition of health as a human right

Canada should make clear its recognition of the right to health as understood in such international treaties as the Covenant on Economic, Social and Cultural Rights to which it is a party, by stating this commitment at the highest domestic level possible:

- In the Charter
- Pending achievement in the Charter in relevant Federal Acts, including the Canada Health Act and the Canadian Human Rights Act.
- Including the right in any "Health Charter" or similar policy guidance document.
- Encouraging and ensuring that related Provincial legislation embodies a parallel commitment.

Health impact assessments of trade agreements

The case of tobacco control discussed in Section 3 indicates the risk of not integrating health concerns a priori into trade agreement negotiations. We do not mean here health care but, rather, well known and important health determinants. Health Canada, supported by independent researchers and health non-governmental organizations, should develop a stronger and more
publicly transparent involvement with trade policy negotiations. This could include supporting comprehensive health impact assessments of existing trade agreements, undertaking assessments of agreements currently in negotiation and advising negotiators, parliament and the Canadian public of health implications of such agreements before Canada commits to them. This would ensure that such agreements do not restrict Canada’s ability to formulate future policies on important health determinants, ranging from tobacco to more general conditions identified in this paper’s Introduction. Such assessments could be jointly organized with Health Canada and the Department of Foreign Affairs and International Trade (DFAIT). DFAIT has been applying the "Strategic Environmental Review" to trade treaties and could draw lessons from its experiences with the development and use of this environmental framework for the development of a health impact assessment. We note that public participation is an integral component of the Strategic Environmental Review.

**Leadership on investment in global health, including global health research**

As a concrete action to support health as a right for all, the Canadian government can take greater international leadership by committing itself strongly to the intervention strategies and donor requirements identified by the extensively researched Commission on Macroeconomics and Health (WHO, 2001). As the health of Canadians is increasingly linked to the health of citizens of other nations, Canada already recognises the importance of global health and invests resources in the provision of such public goods. However, to reflect our values of equity and access, greater investments are needed. Canada will also need to urge other donor countries to collaborate in this endeavour, given its relatively small economic weight. To attain the health targets of the Millenium Development Goals and to mobilize the resources to achieve them, strong political leadership will be required in Canada and abroad.

**Strengthening health oversight in trade disputes**

The increasing deference to international standards, such as Codex, by SPS dispute panels is problematic, as these are often less stringent than many countries’ domestic standards. More stringent domestic measures may be permitted, but only if they have been subject to risk assessments which, though useful policy tools, are costly and methodologically controversial. One important means of improving the odds that trade does not trump public health concerns in
such cases is to reverse the burden of proof in all such disputes. The onus could be on the disputing country to prove the exception was not intended to protect human or environmental health (GATT XX(b)), i.e., that its intent is protectionist; or, in the case of SPS, to provide risk assessments indicating a product, disallowed on health grounds in one country, is safe. This, in fact, embodies the position of the Government of Canada as articulated in recent discussion papers on the precautionary principle (2001a, 2001b). These papers also claim the importance of taking into account "societal values, public willingness to accept risk, and economic considerations" as well as scientific risk assessments in decision-making, yet these considerations were not accepted by the SPS dispute panel ruling on Canada’s (and the US’s) successful complaint over the EC’s beef-hormone ban.

**Strengthening environmental oversight of trade agreements**

The Doha Declaration provides an opportunity for granting observer status to Secretariats responsible for Multilateral Environmental Agreements, and for representatives from UNEP, in the WTO Committee on Trade and the Environment. This is still being negotiated by this WTO Committee and the extent of their role remains uncertain. Canada’s WTO negotiators could advocate a stronger presence and role of MEA Secretariats and UNEP officials in WTO trade policy meetings, i.e., ex officio but full participatory status. We believe this would be consistent with the Doha Declaration, and with Canada’s obligations to protect global environmental resources and ecosystems as global public goods.

**Strengthening other stakeholder sectors and civil society participation**

Both the WHO and PAHO have small groups undertaking research and analysis on the trade-health linkage. The work of these groups includes research, policy analysis, training, Member State consultations, documentation of "best practices" (with respect to integrating health concerns in trade agreements/negotiations) and support for global networks of trade-health researchers and policy analysts. Canada could consider targeting increased support for these functions, and having its trade negotiators urge more formal participation by these groups in WTO negotiating meetings. Canada can also play a stronger international leadership role in developing alliances with civil society groups, government departments and international institutions. It could support the creation of a "Like Minded Group on Health" amongst WTO
Member States, a domestic "Expert Group" on health – trade – globalization with formal linkages to government departments engaged in trade policy discussions (taking advantage of the recently formed Canadian Coalition on Global Health Research and the recently signed MOU on global health by CIDA, IDRC, Health Canada, and CIHR).

In recent years, the Canadian government has adopted a number of new participation and consultation mechanisms for Canadians in foreign policymaking. For instance, the Canadian Centre for Foreign Policy Development of the Department of Foreign Affairs and International Trade (DFAIT) has a mandate to involve Canadians in the development of our foreign policy. The Center could focus some of its activities on global health, to ensure that the three policy spheres – health, foreign affairs and international trade — are not undertaking contradictory initiatives. Another option is to include more public health representatives in the Sectoral Advisory Groups on International Trade (SAGITs) which advise the government on trade policymaking.

**Promotion of the Canadian model based on equity and access in CIDA programming**

Projecting the Canadian value of health as a human right also means supporting concrete policies working toward greater access and equity in health. Our support for policy development in the health sector in developing countries should promote these principles of the Canadian model. The Canada-Brazil Technology Transfer Fund is one example of how such programming can be designed. This program funds the sharing of Canadian approaches, models and expertise with partner organisations in three areas: social development (health, education, human rights), environment management and public sector reforms. The objective of the program is to contribute to the achievement of greater equity (CIDA, March 2001).

**Ensuring PRSPs Work to Promote Health and Reduce Poverty**

Despite the widespread acceptance of the potential value of PRSPs, and that they have accomplished some benefits to date, Canada’s involvement with the PRSP process requires careful attention to its many present shortcomings. To aid in offsetting these, Canada can ensure that its ODA and PRSP support embody the "pro-poor" health strategies identified by the WHO (2001, addendum to World Bank/IMF 2002). These criteria can serve as a screen in Canada’s
own ODA commitments to health. It can also be the position taken by Canada’s representatives to the World Bank and IMF, where funding decisions under the PRSP and HIPC initiative are made. The WHO’s criteria can also be reviewed and amended by empirical assessment, facilitated through the research linkages between Canadian global health organizations, researchers and NGOs involved in the newly formed Coalition for Global Health Research - Canada.

**No active recruitment of health professionals from developing countries**

The migration of health professionals from developing to industrial countries is not a new problem. However, with the worsening of the shortage of nurses and physicians in Canada, we should ensure that we do not endanger the health systems of developing countries by actively recruiting their professionals to manage our human resources problems. Adopting a guideline similar to the UK Department of Health prohibiting active recruitment would be a first step to limiting the damage of the South-North brain drain.

**Consistency in Global/Domestic Tobacco Policy**

The tobacco example illustrates the importance that Canada, in its work on the FCTC, ensures that the health convention takes precedence over trade agreements. Canada must also create more consistency in its domestic/foreign tobacco policy, i.e., ensure that its trade interests in tobacco exportation in no way compromise both the general intent (tobacco reduction) and eventual requirements of the FCTC. Canada should no longer seek tobacco markets in developing countries; and should support such countries in adopting tobacco control strategies that Canada implements domestically.
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ANNEX

Table A
Financial commitments to health recommended by the Sachs Commission
(in billions US dollars)

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2007</th>
<th>2015</th>
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<tr>
<td><strong>Donor commitments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- for least-developed countries</td>
<td>1.5</td>
<td>14</td>
<td>21</td>
</tr>
<tr>
<td>- for other low-income countries</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>- for middle-income countries</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>- for research and development</td>
<td>&lt; 0.5</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- for international agencies</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total donor financial commitments</strong></td>
<td>7</td>
<td>27</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Domestic resources for health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- in least-developed countries</td>
<td>7</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>- in other low-income countries</td>
<td>43</td>
<td>62</td>
<td>74</td>
</tr>
</tbody>
</table>


Note: The set of interventions covered by this major scale up are the following: TB, malaria and HI/AIDS prevention and treatment (including treatment of opportunistic infections linked to HIV/AIDS), immunization, maternal care).
Table B
Aid to health 1990-1998: OECD annual average commitment and share in total aid
(USD million and %)

<table>
<thead>
<tr>
<th></th>
<th>Volume in USD million</th>
<th>Aid to health as % of total ODA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>14</td>
<td>43</td>
</tr>
<tr>
<td>Austria</td>
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<tr>
<td>Belgium</td>
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<td>Finland</td>
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<td>800</td>
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<td><strong>TOTAL DAC</strong></td>
<td><strong>1286</strong></td>
<td><strong>1841</strong></td>
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### Table C

Selected OECD countries's ODA performance (in USD million)

<table>
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<tr>
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<th>2000</th>
<th>Additional funds available by meeting the 0.7 % target</th>
<th>Percent of GNI</th>
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<tr>
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<td>1985-89 average</td>
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<tr>
<td>TOTAL OECD's DAC members</td>
<td>53737</td>
<td>----</td>
<td><strong>0.33</strong></td>
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OECD, 2002.