

Trade and Health 1



Managing the pursuit of health and wealth: the key challenges

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This article forms part of a six-part Series on trade and health, and sets the stage for this Series by analysing key aspects of the relationship between trade and health. The Series takes stock of this relation and provides timely analysis of the key challenges facing efforts to achieve an appropriate balance between trade and health across a diverse range of issues. This introductory article reviews how trade and health have risen and expanded on global policy agendas in the past decade in unprecedented ways, describes how trade and health issues are respectively governed in international relations, examines the ongoing search for policy coherence between the two policy spheres, and highlights the topics of the remaining articles in the Series.

Introduction

The sharp rise in food and energy prices, the decline of stock markets worldwide, and the deepening global financial crisis, remind us that the global economy binds the prosperity of countries together like never before. Underpinning the global economy are unprecedented flows of international trade in goods, services, and capital, all of which sustain livelihoods around the world and affect the daily lives of billions of people. Global concerns about the potential adverse consequences of the July, 2008, collapse of the Doha Round of multilateral trade negotiations further underscore the critical importance of international trade.

The global reach of international trade also extends far beyond the economic realm into the health sector. Trade and health have been historically intertwined but have tended to operate as separate policy spheres. In recent decades, globalisation has brought these spheres closer together. Access to patented medicines protected by trade agreements, use of treaties to liberalise trade in tobacco products, growing trade in health services, and the effect of expanded trade on health equity within and across countries, are all examples of the increasingly important nexus between trade and health. Although some of these issues have led to closer cooperation, others have exposed tensions between the goals of protecting and promoting health, and generating wealth through trade.

This article is the first in a Series on the rapidly expanding agenda on trade and health, an agenda requiring joint policy attention.¹⁻⁵ The Series takes stock of this relationship, a fluid and often controversial subject. Both trade and health have reached turning points as issues in world affairs, and this Series provides timely analyses of key challenges facing efforts to achieve an appropriate balance between the two spheres across a diverse range of issues. Of particular interest is how health can best be protected and promoted amid rapidly expanding trade relations.

This first article sets the stage for this Series by addressing key issues that define the trade and health linkage. We focus first on how, in the past decade, both

trade and health have risen and expanded on global policy agendas in unprecedented ways. We then describe how the trade and health relationship is governed in international relations. This analysis reveals a contrast between trade's structured and formalised governance system, and the unstructured plurality that characterises global health governance. This difference helps explain why trade agreements dominate the trade–health relation. More detailed analysis of governance issues is provided in the second paper.¹

This article also examines the ongoing search for policy coherence between the two spheres. Policy coherence requires handling both direct and indirect links between health and trade, which pose different policy and governance challenges. The trade and health nexus represents a daunting agenda for national governments, intergovernmental organisations (IGOs), the private sector, and non-governmental organisations (NGOs). We conclude by describing the remaining articles in this Series, which collectively seek to stimulate efforts to align the pursuit of health and wealth in a sustainable and mutually beneficial manner.

The rise of trade and health in world affairs

The current relation between trade and health exhibits unprecedented breadth, depth, and intensity. Historically, the oldest manifestation of this interface has been the concern that trade spreads disease. Long before germ theory developed, governments adopted measures to prevent the importation of diseases associated with trade, such as plague and cholera.⁶ The growth in the use of quarantine measures, and the expansion of trade in the 19th century, led states to engage in more systematic cooperation.⁷ The international sanitary conferences and conventions, of the latter half of the 19th and first half of the 20th centuries, constituted the first efforts at policy convergence, namely to produce international law that attempted to balance trade and health objectives.⁸

Invariably, this convergence was defined by the trading powers of the day, was ostensibly framed to protect their trading interests, and gave no attention to

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This is the first in a Series of six papers on trade and health

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the negative health consequences of imperialism arising from the economic exploitation of colonised territories. Thus, the narrow scope of this early policy convergence focused on minimising the burden that national health measures (eg, quarantine) imposed on the trading interests of the most economically powerful countries. Disease surveillance and data collection were limited to a handful of acute epidemic infections (eg, cholera, plague, and yellow fever), the spread of which was associated with trade. The measures adopted focused on actions to be taken at the border to protect trading powers from external threats, and did not require states to improve, for example, health determinants within their own territories, let alone population health in other countries.

Not until the latter half of the 19th century did actions, alongside the adoption of international sanitary measures, begin to improve conditions for labourers, albeit focused on the industrialising economies of Europe. The exploitation and appalling conditions in which factory workers toiled and lived fed the emergence of communism and stimulated the eventual development of the International Labour Organization (ILO) and labour standards after World War 1, including occupational safety and health protections.⁹ This period also witnessed efforts to address the negative health and environmental consequences of transboundary pollution arising from industrialisation.¹⁰ Unlike the international sanitary conventions, these measures focused attention on health conditions and standards within countries, as well as on the responsibilities of states not to cause spill-over harm in other countries as a result of their economic activities. Adverse effects on health associated with industrialisation implicated trade because industrial products were often the goods traded in international commerce. Competition from cheaper imports created pressures to reduce costs, often pursued at the expense of worker health and safety, and environmental degradation. This situation led to the ILO's efforts to harmonise labour protections across countries, and attempts to control transboundary pollution through international standards and treaties.

Attention to the direct and indirect links between trade and health waned during the Cold War. The General Agreement on Tariffs and Trade (GATT),¹¹ adopted in 1947, and the International Sanitary Regulations (ISR, which later became the International Health Regulations [IHR]),¹² adopted by WHO in 1951, included provisions for balancing trade and health interests. However, although occasional controversies arose,¹³ GATT's development did not include substantial efforts to address policy linkages. Trade became caught up in the geopolitical struggle between the USA and the Soviet Union. The trade and health relation was marginalised in the process.

In international health cooperation, WHO efforts to improve health in developing countries, through such strategies as promoting the right to health, Health for

All, the Essential Drugs List, and International Code on the Marketing of Breast Milk Substitutes, began to raise deeper questions about the health implications of certain economic activities, including trade. As support by developing and socialist countries for a New International Economic Order intensified in the 1970s, the Health for All Initiative and Declaration of Alma Ata became entangled in disputes between western countries, the Soviet bloc, and the developing world.¹⁴ The bitterness of these conflicts ensured that little constructive attention was focused on the connection between trade and health. Instead, the focus on infectious diseases and trade continued through the IHR, but even these regulations faded in policy relevance as the Cold War persisted.¹⁵

The interface between trade and health has changed substantively since the end of the Cold War, characterised foremost by a greater convergence of policy issues. The shift of the ideological struggle, characterised by the ascent of neo-liberalism after the Cold War, leavened the international system for the expansion of trade. Initially begun under GATT, this process has been accelerated under the far-reaching provisions of the World Trade Organization (WTO). When established in 1947, GATT had 23 contracting parties and was limited to trade in goods.¹⁶ Today, the WTO has 153 members¹⁷ (which account for 97% of world trade¹⁸), with another 29 countries seeking accession,¹⁹ and includes trade in goods and services and the protection of intellectual property rights. Trade liberalisation—the lowering of restrictions on and barriers to the cross-border exchange and movement of goods, services, and investment capital—has emerged in the post-Cold War period as a leading political and economic strategy in advancing objectives in world affairs. Importantly, almost all post-Cold War strategies for development have promoted trade and its expansion as critical to economic growth, including lifting people living in developing countries out of poverty.²⁰

Simultaneously, the prominence of health issues in global politics has increased substantially since the 1990s, in part reminiscent of the 19th century in being defined by the preoccupations of powerful political and economic interests. This prominence has been particularly notable regarding the perceived threats posed by emerging and re-emerging communicable diseases and biological terrorism. Additionally, health has featured prominently in new human rights and development initiatives, such as the Millennium Development Goals. Although not all health issues have been afforded the same degree of high-level political attention, support for global health has been notable, especially as health has become more tightly linked to security, economic development, and humanitarian concerns. Consequently, addressing global health issues is now perceived as central to national and international cooperation, as shown by the rise of health on foreign policy agendas.²¹

The acceleration of trade liberalisation, combined with the increased prominence of global health, over the past decade or so has produced the seminal policy convergence we see today. This convergence encompasses direct (eg, link between trade and pathogen spread) and indirect (eg, trade's effect on the broad determinants of health) policy links. Although this convergence echoes issues from earlier periods, the unprecedented breadth, depth, and intensity of trade-health linkages pose new challenges.

The current policy agenda covers flows of trade in industrial and agricultural goods, health-related services, protection of intellectual property rights and investment capital, and the varied effects of such policies across a range of communicable and non-communicable diseases and health services provision and financing. The convergence of trade and health issues requires both areas to adjust to the policy importance accorded to the other. Finding effective ways of making such adjustments has generated controversy because such changes might substantially affect how states exercise their sovereignty. With much at stake, outcomes are also likely to be shaped by unequal political and economic power among countries, and differences in values and policy goals, including how the importance of equity in the distribution of health and wealth is perceived.

Trade, health, and governance

Balancing trade and health policies requires cooperation through international institutional mechanisms. Comparing the mechanisms within the two realms reveals why trade has so far dominated governance of this relationship. International trade has a highly structured, formalised, and demanding governance system. By contrast, global health governance exhibits little structural coherence, a greater diversity of actors and approaches, and weaker legal obligations on states.

The WTO is the centre of authority for the governance of trade, as indicated by the large number of its member states and the substantive reach of its agreements. Other articles in this Series examine the health implications of specific WTO agreements, such as the General Agreement on Trade in Services (GATS)²² and the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).²³ Here, we emphasise cross cutting WTO features that affect the trade–health relationship.

The first feature reflects how the WTO facilitates trade among member states through centralised and comprehensive governance architecture. The strategic objective of trade liberalisation within a multilateral system has produced a core structure with strong legal foundations (eg, GATT) and the incentive and capacity to handle new issues (eg, GATS, TRIPS). This architecture contrasts with the unstructured plurality of governance in global health.²⁴ Rather than centring around WHO, global health governance has fragmented, diversified, and multiplied in ways that challenge

WHO's lead role as the UN specialised agency for health.

Second, the WTO's political and substantive scope is crucial to understanding its effect on trade and health issues. Politically, WTO's membership is extensive and expanding. This reality shows the WTO's importance to developed and developing countries. In 13 years, the WTO has become one of the most important IGOs because of the widely shared perception that economic growth and public welfare depend on participation in a robust system of international trade.

By contrast, WHO's influence mainly derives from its technical expertise used in the promotion of non-binding collective action across its member states (eg, eradication of smallpox and polio). WHO is also expected to address new and emerging global health issues, such as public health innovation and intellectual property rights, and sharing of influenza viruses and related benefits. Only recently have member states used WHO as a forum to negotiate international legal instruments (the Framework Convention on Tobacco Control²⁵ and the International Health Regulations [2005]²⁶).

Substantively, the scope of issues covered by WTO agreements is breathtaking. To become a WTO member, a country has to agree to accept no less than 17 main multilateral agreements and 60 agreements, annexes, decisions, and understandings that contain binding obligations on, among other things, tariffs and non-tariff barriers on industrial and agricultural goods; trade in all kinds of services; application of measures to protect human, animal, and plant health (sanitary and phytosanitary measures); implementation of technical barriers to trade; use of trade-related investment measures; imposition of additional tariffs on dumped or subsidised imports; and protection of intellectual property rights. The large number of WTO member states means that most of the international community has committed itself to implementing this vast array of obligations.

Although the WHO Constitution contains a broad definition of health, WHO membership does not involve acceptance of multiple, extensive legal obligations. The WHO Constitution does not require member states to accept other international legal duties,²⁷ so WHO membership lacks the broad, deep, and binding commitments WTO membership imposes. This observation does not mean that WHO member states refrain from entering into other international agreements. These other arrangements, such as human rights instruments that include the right to health and environmental treaties that seek to protect human health, have arisen outside WHO's auspices, creating a patchwork effect rather than a centralised, integrated set of legal obligations on health.

Third, WTO agreements place extensive demands on individual countries. Each WTO agreement contains detailed, complex, and legally binding requirements that seriously discipline the sovereignty of WTO member

countries. These requirements test the skill of trade lawyers, let alone health experts coming to this field without training. By contrast, WHO membership is not legally demanding on states, and historically other international legal agreements directly affecting health, have not contained extensive duties (eg, the ISR/IHR) or detailed and specific requirements (eg, human right to health). Additionally, voluntary membership in new global health initiatives, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria²⁸ and the International Finance Facility for Immunisation,²⁹ have not been created through treaty law and thus do not impose legal obligations on participating states.

Fourth, the WTO reinforces the scope and demanding nature of its rules through its dispute settlement mechanism. Unlike most areas of international law, the WTO's dispute settlement provisions are comprehensive, covering disputes under all mandatory WTO agreements, and are compulsory.³⁰ This combination makes the WTO dispute settlement mechanism an authoritative source of interpretation for its agreements. Additionally, the WTO dispute settlement mechanism allows member countries prevailing in disputes to use trade sanctions to enforce rulings against member states that fail to comply with decisions. In view of the number of WTO member states and the demanding nature of many WTO rules, authoritative interpretations and the potential for enforcement carry far-reaching implications for trade and other policy efforts that trade liberalisation affects. Decisions by WTO dispute panels and the Appellate Body (the appeals chamber of the WTO dispute process) therefore become focal points for the governance of trade's relationship with other areas, including health. The importance of the WTO's dispute settlement mechanism has drawn much attention to how it functions, and proponents and critics of the mechanism's structure and performance are abundant.

By contrast, health-specific legal agreements, such as the Framework Convention on Tobacco Control or the revised International Health Regulations (IHR 2005), do not contain compulsory dispute settlement and enforcement provisions, and thus lack the compliance bite that WTO rules have. This difference could affect how seriously countries take obligations connected to the two organisations. Consequently, the WTO dispute settlement mechanism heightens the political and economic significance of compliance with WTO rules, including those rules that could affect health policy.

The above features of the WTO help explain why governance of the trade–health relationship is weighted toward international trade law. Although it raises concerns about the future of WTO's centralised architecture, the proliferation of regional and bilateral trade agreements reinforces international trade law's dominant governance role in the trade and health arena. These observations do not discount health's increased political importance, but they highlight that this

prominence exists in a governance context marked by the WTO system. Efforts to shift governance of trade and health away from trade agreements have proven controversial and not entirely effective, as witnessed by problems concerning intellectual property rights. This context draws attention to larger political questions that focus on why governance of trade relations and health problems in international relations are markedly different. These questions force consideration of the relative weight given to trade and economic issues by states in the formulation of their national interests.

Therefore, a key question becomes whether this governance environment permits countries to pursue trade and health interests in ways that do not privilege one area to the detriment of the other. The second paper in this Series examines the governance of trade and health in greater detail, including the prospects for achieving more appropriate and effective policy coherence between trade and health.

Towards policy coherence

The greater convergence of trade and health issues, given the current dominance of trade governance, creates important challenges for the public health community. Policy coherence requires common ground with respect to substantive policy objectives, which is often not easy to find or construct because of divergent public and private interests. The search for policy coherence is also complicated by the need for a broad agenda because trade and health have direct and indirect links. In addition, trade and health coherence has to be achieved within and across individual countries. Other papers in this Series explore specific areas of this trade–health relationship, but here we provide general considerations about the intensifying search for policy coherence.

An initial challenge is developing clearer evidence of how trade affects population health and health policy. Where the link is direct, such as trade in goods contaminated with harmful pathogens or containing dangerous substances, coherence analysis focuses on whether specific trade-restricting health measures comply with particular rules in trade (eg, GATT) or health (eg, IHR 2005) agreements: for example, was the measure applied in a non-discriminatory manner, based on scientific evidence, or the least trade-restrictive measure reasonably available to achieve the level of health protection sought? Controversies arise in applying these trade and health rules (eg, how much scientific evidence is sufficient?), but these questions are rule-based, require case-by-case factual determinations, do not invite ideological debate, and make good candidates for dispute settlement. For example, whether a WTO member has done an adequate risk assessment before imposing a trade-restrictive measure is a question frequently adjudicated before the WTO dispute settlement mechanism in the area of sanitary and phytosanitary protection.

The coherence allowed by each rule must be assessed by the rule-based, case-by-case analysis of direct link problems. Some rules, such as the prohibition on discriminatory trade measures, might pose no concerns for health. Health officials do not need to discriminate on the basis of the origin of a product in order to protect health from direct trade-related threats because such a basis finds no support in scientific principles or evidence. Other rules, such as the requirement for trade-restricting health measures to be the least trade-restrictive measures reasonably available, raise more coherency concerns. Disagreements arise over whether one measure is more or less trade restrictive than another, and over whether the least trade-restrictive measure is actually feasible for the country in question to implement. These issues hinge on how states or dispute settlement mechanisms interpret the rules. Authoritative interpretations of WTO rules have a uniformity of meaning across the international system, even if the meaning remains controversial among some states and non-state actors.

The possibility of policy coherence from the application of the rules does not, however, ensure policy coherence in practice. Countries might not take advantage of the policy space they are afforded by trade and health governance mechanisms. But such failures to act could flow from lack of political will, competence, or capability rather than the presence of skewed rules. For example, many direct link contexts (eg, liberalising trade in health-related services³¹) require sophisticated analysis in order for policy makers to achieve their political and economic objectives (eg, wealth creation, economic and health equities) for their populations.

Even greater difficulty can arise when there is an indirect causal relationship between trade and health. For example, trade could affect macroeconomic conditions that, in turn, influence employment levels and income equities, which affect access to health services. Or, trade might form only part of the explanation for certain problems (eg, access to essential medicines, the growth in obesity-related diseases, health harms from environmental degradation). Where such indirect links exist, what coherence should look like, how it should be achieved, and how it relates to concepts of fairness and equity, constitute more difficult questions because of the substantial number and nature of the variables to be analysed and regulated. Simplistic responses, such as ignoring trade's indirect effect on health or blanket opposition to trade liberalisation, do not provide foundations for policy coherence.

Where indirect links exist, coherence analysis is not typically rule-based and does not proceed through case-by-case determinations of trade measures applied to products or services. Rather, analysis of indirect trade–health links tends to lead to big picture questions that invite debate about larger governance challenges. For example, if data indicate that government health

expenditures declined because tariff revenues decreased under trade liberalisation agreements, is the proper response to restrict trade by increasing tariffs, or to find strategies for financing health care that are not dependent on high, fixed tariff rates? Or, if trade liberalisation leads to economic growth but, at the same time, also leads to greater income inequality which, in turn, reduces access to health services, what is the appropriate policy response: higher trade barriers, more progressive taxation of incomes, or increased health-care expenditure? More broadly, does the combination of trade liberalisation strategies and other policy reforms (eg, deregulation of the economy, privatisation of government-run services) unduly limit the range of options available for addressing inequalities in income and inequities in access to health services?

The application of treaty interpretation principles does not provide answers to these broader policy choices, nor would there be uniformity in the answers across all countries. Achieving policy coherence in situations of indirect links often does not involve simultaneous balancing of trade and health interests in specific cases under detailed rules. Rather, it unfolds through separate responses in distinct policy spheres using multiple instruments at different times (eg, liberalise trade internationally through trade law, redistribute wealth domestically through national fiscal measures, and reform access to health services through health policy). Additionally, indirect links raise ideological considerations because the issues invite discussion of value-based preferences within and among societies.

The indirect link between the international trade of foods and drink, and the obesity pandemic, provides a good example of these analytical dynamics. Trade constitutes only one variable in a complex set of factors that contribute to obesity.³² There is no evidence to show that addressing obesity specifically through direct trade policies (as opposed to general economic measures applicable to all goods and services, such as marketing restrictions) would be effective. The complexity of the obesity problem invites expression of political perspectives that frame responses to obesity in different ways—“preventing and controlling obesity is an individual responsibility not the duty of the ‘nanny State’” versus “obesity management requires government intervention to protect vulnerable individuals from corporate exploitation.”

As the obesity example illustrates, what policy coherence between trade and health actually means in practice is difficult to pinpoint. Management of such indirect links requires more than fine-tuning the application of specific rules under trade and health agreements. What is feasible in addressing indirect links would vary from country to country, and conceptions of equity and fairness differ between trade and health sectors within and between countries. These observations apply, for example, to tensions over the

protection of intellectual property rights, an issue on which coherence has remained technically, politically, and philosophically elusive.

To make things more complicated, the larger political footprint of indirect link problems also invites analysis on how such problems get managed in trade and health venues. Do the strong do what they will, while the weak suffer, or are trade and health governance mechanisms capable of producing more symmetry between trade and health interests in indirect link areas?

Conclusion

The relation between trade and health in the early 21st century is as important as it is complicated and controversial. The greater convergence of trade and health issues in the past few decades, the existing governance mechanisms to address this relationship, and the ongoing search for policy coherence nationally and globally all raise major challenges. The profound effect international trade has on our daily lives means that resolving these challenges will be imperative to finding appropriate ways to manage the pursuit of health and wealth. The purpose of the remaining articles in this Series is to flesh out this imperative through analysis of key inflection points in trade and health.

The second paper¹ delves more deeply into the governance challenges, tracing the origins of the global trading system and international health cooperation. As well as the differences in the two policy spheres described above, the paper assesses how effectively the two systems come together, and how current deficits in the representation of health interests within the governance of international trade might be addressed. The third paper² scopes out the indirect effects of international trade agreements on health that are mediated through the broad determinants of health such as poverty, inequality, economic insecurity, and diet and nutrition. The fourth paper³ examines the increasingly important trade in health services within the context of the General Agreement on Trade and Services (GATS). The fifth paper⁴ sets out the complex and controversial debates surrounding the implications for health of trade-related intellectual property rights protections, notably access to medicines. The final paper in the Series outlines three priority areas in terms of the major challenges faced and actions required.⁵ These papers form the basis of a trade and health Agenda for Action.

Trade and health policies are at turning points in their respective political and governance trajectories. The WTO's Doha Development Agenda has stagnated, leading to an explosion in regional and bilateral trade agreements, the portents of which for the trade-health linkage remain uncertain, especially in the controversial area of protection of intellectual property rights (see the fifth paper in this series).³³ Global health's rise to political prominence has stimulated hard questions about whether countries, IGOs, the private sector, and NGOs will

harness or squander this prominence within and beyond the world of trade. The breadth, depth, and intensity of the link between trade and health connect these two trajectories in ways vital to the prospects of both policy endeavours.

Trade and health have a long history that has seen these areas converge and diverge at different points in time. The current convergence, and the search for coherence, will define the trade and health relationship for decades to come. Whether those in both policy communities understand fully the trade and health imperative, and its technical and political challenges, will influence how these crucial objectives in global affairs will shape the future of states and their peoples.

Conflict of interest statement

We declare that we have no conflict of interest.

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