PostScript

LETTER

Trade and public health: facing the challenges of globalisation – author's response

We welcome Richard Smith's editorial on part 1 of our glossary and applaud its caution that our glossary be accepted as a first, but not last, word on the topic.^{1,2} In turn, we have a few cautions of our own to add to Smith's.

First, we regret if our glossary implies that we view trade as a threat to public health or consider the World Trade Organization (WTO) and its trade treaties to be singularly negative. Neither is the case. Our concern, instead, was with those aspects of trade and trade treaties where a public health risk demonstrably does exist, or without additional safeguarding by national governments or within trade treaties themselves, could likely exist. We assumed, perhaps incorrectly, that the benefits of trade (real or putative) were so commonplace in mass media that they did not require more than passing reference.

Second, we concur completely with Smith's comments on the power of globalisation in its enhanced communicative technologies to do tremendous public health good, the importance of health officials demonstrating the economic costs of failing to invest in a public health infrastructure and the importance of a multilateral trading system in which at least formal equality between the players exists. But the first two do not rely on trade treaties, and the multilateral trading system itself (the WTO) is now in tatters for the very reasons we cautioned in part 2 of our glossary.³ As developing countries became more powerful and organised within the WTO (translating formal into more effective democracy), the established wealthy nations would walk away in favour of less transparent and far less equitable bilateral trade agreements. That is precisely what the US and the European Union have done, each blaming the other for refusing to budge on agriculture (where poorer exporting countries hold some comparative advantage), while demanding rapid tariff reductions by developing countries on industrial tariffs (where the US and European Union hold most of the comparative advantage). Reflecting their own national mercantilist interests, they have effectively killed what was to have been a "development" round in which the needs of poorer nations were supposed to have been paramount.

Third, and building on this last point, the arguments Smith cites in defence of comparative advantage have come under criticism among economists themselves. This theory evolved at a time when capital and labour were immobile, nations of relatively equal wealth traded with each other on the basis of the specific resources or specialised skills they possessed and assumed that winners would compensate losers. Although not without contemporary relevance, it may not be the trade theory best suited for a time when national inequalities have risen 50-fold and much of the world's trading takes place between different units of the same transnational corporation.

Fourth, it is also almost axiomatic in development economics that reliance on the export of primary commodities (especially agricultural produce, where poorer nations hold comparative advantage) is a blind alley to sustained growth or poverty reduction. Value-adding economic development requires the protection of infant industries (until they become more efficient) and reverse-copying of technologies as a catch-up. This is precisely how today's mature economies grew, and is now significantly constrained by trade treaties.

Fifth, embodying these special requirements of developing nations within trade treaties through strengthened special and differential treatment, another promise on which the Doha round failed to deliver, would still not overcome the problems of environmental externalities (what moves goods and people around except fossil fuel?) or jobless economic growth (a plight that is now facing the current Asian tigers, China and India, the result of capital-intensive manufacturing replacing earlier labour-intensive agriculture or less efficient methods of production).

Sixth, although we are less sanguine than Smith on the prospects of multilateral trade rules (which are effectively commercial rules) in delivering equitable access to health goods, services and people, we do agree that there is a need for more good studies and less rhetoric on the relationship between trade and health. This is all the more urgent as the first great experiment in "free" global trade has run aground on the reefs of rich world protectionism. It is premature to declare the WTO dead: it still administers a large number of trade treaties. But the most important venue for public health engagement around trade and health is probably shifting to regional and bilateral levels, rendering the tasks more difficult by volume alone, but no less important.

Finally, as Nancy Birdsall and her colleagues at the Centre for Global Development, Washington DC, USA, have shown empirically,

the global market is prone to failures that are disproportionately borne by most developing countries, notably the poorer 40–80% within them.⁴ Because of this, she argues (and is not alone in this) that "we need global arrangements that, via some mechanisms equivalent to the usual taxes, subsidies, and regulatory arrangements we have in modern capitalist economies, reduce the difference between individual country returns and the social return to the global economy and all its players. Thus the discussion of whether globalization and openness are good or bad for the poor should move on to a discussion of the appropriate global social contract and appropriate global arrangements for minimizing the asymmetric risks and costs of global market failure."⁴

Correspondence to: Professor R Labonté, Canada Research Chair, Globalization/Health Equity, Institute of Population Health, Faculty of Medicine, University of Ottawa, 1 Stewart Street, Ottawa, Ontario, Canada K1N 6N5; rlabonte@uottawa.ca

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- 2 Labonté R, Sanger M. Glossary on the World Trade Organisation and public health: part 1. *J Epidemiol Community Health* 2006;**60**:655–61.
- 3 Labonté R, Sanger M. Glossary on the World Trade Organisation and public health: part 2. *J Epidemiol Community Health* 2006;**60**:738–44.
- 4 Birdsall N. Stormy days on an open field: asymmetries in the global economy. UNU-WIDER Research Paper Number 2006/31. <http://www.wider.unu.edu/publications/rps/rps2006/rp2006-31.pdf>.

CORRECTION

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Marrugat J, Subirana I, Comín E, *et al.* Validity of an adaptation of the Framingham cardiovascular risk function: the VERIFICA study (*J Epidemiol Community Health* 2007;**61**:40–7). The affiliation for Rafel Ramos was inadvertently omitted on publication of this paper. Dr Ramos' affiliation is: Doctorat en Salut Pública i Metodologia de la Recerca Biomèdica, Universitat Autònoma de Barcelona, Barcelona, Spain. The authors apologise for this error.