LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

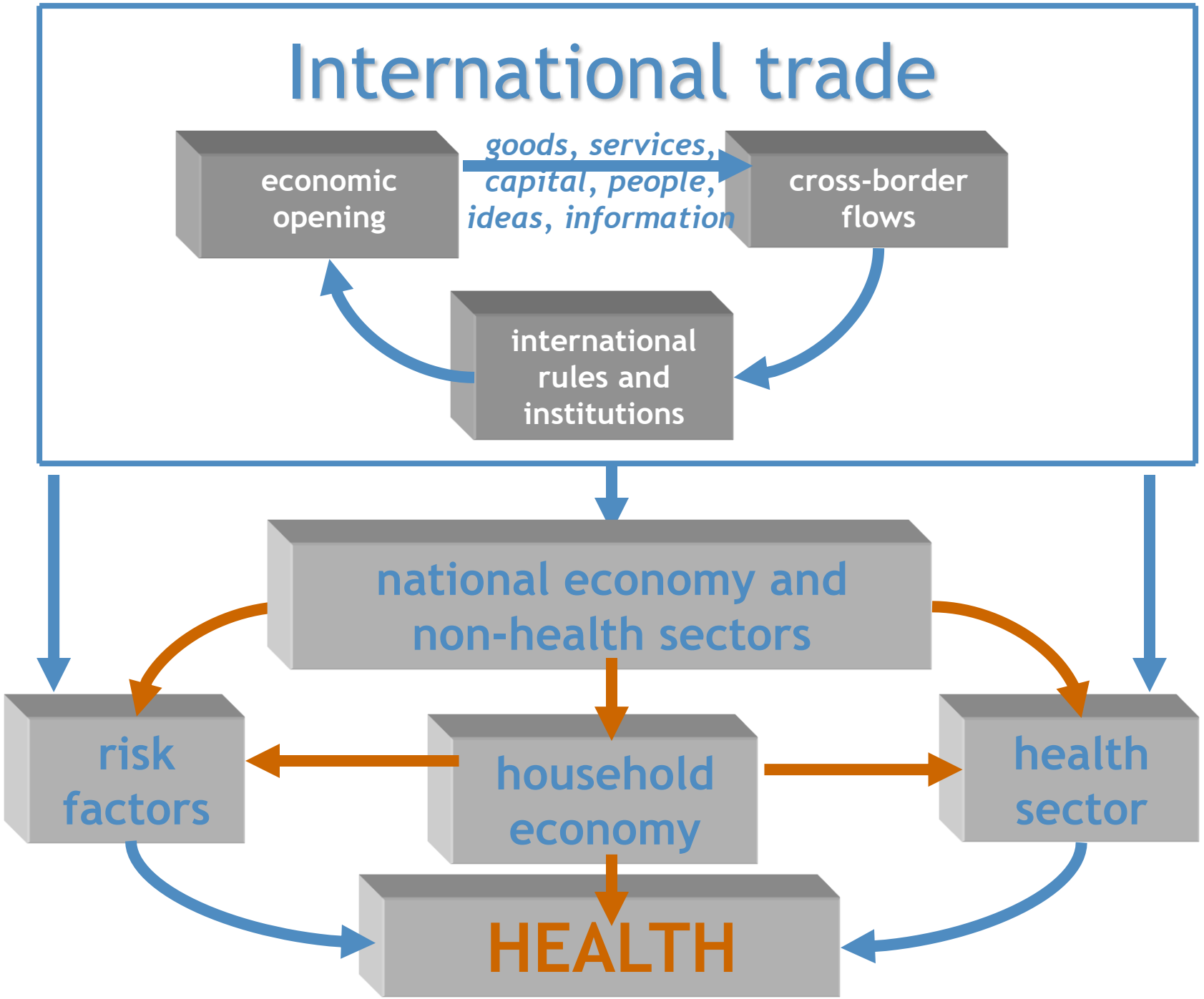
Shaping the future of health policy: the role of trade

Richard Smith

Professor of Health System Economics

Dean of Faculty of Public Health and Policy


ENGLAND
(ENG)
ROAD TO RUSSIA
EUROPE
THE FOOTBALL ASSOCIATION
572
573
Joe Hart
574
Jordan Pickford
575
Gary Cahill
576
KYLE WALKER
John Stones
578
RYAN BERTRAND
DANNY ROSE
PHIL JONES
64 ENG
2018 FIFA WORLD CUP RUSSIA™
GROUP G
JORDAN HENDERSON
ALEX OXLADE-CHAMBERLAIN
Dele Alli
584
ERIC DIER
Adam Lallana
586
Jesse Lingard
587
Raheem Sterling
588
Harry Kane
589
Marcus Rashford
590
Jamie Vardy
591
65 ENG


International trade
economic opening
goods, services, capital, people, ideas, information
cross-border flows
international rules and institutions
national economy and non-health sectors
risk factors
household economy
health sector
HEALTH

RESEARCH

Impact of 2008 global economic crisis on suicide: time trend study in 54 countries

OPEN ACCESS

Shu-Sen Chang *research assistant professor*[1 2 3], David Stuckler *senior research leader*[4 5], Paul Yip *professor*[1 6], David Gunnell *professor*[2]

Social Science & Medicine 112 (2014) 39–50

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Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

The impact of fiscal austerity on suicide: On the empirics of a modern Greek tragedy☆

Nikolaos Antonakakis [a,b,*], Alan Collins [a]

MEDICARE SPENDING

By David Dranove, Craig Garthwaite, and Christopher Ody

DOI: 10.1377/hlthaff.2015.0100
HEALTH AFFAIRS 34,
NO. 8 (2015): 1368–1375

The Economic Downturn And Its Lingering Effects Reduced Medicare Spending Growth By $4 Billion In 2009–12

OPEN ACCESS Freely available online

PLoS one

The Impact of Economic Crises on Communicable Disease Transmission and Control: A Systematic Review of the Evidence

Marc Suhrcke[1], David Stuckler[2], Jonathan E. Suk[3], Monica Desai[4], Michaela Senek[1], Martin McKee[4], Svetla Tsolova[3], Sanjay Basu[5], Ibrahim Abubakar[1], Paul Hunter[1], Boika Rechel[1], Jan C. Semenza[3]*

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HEALTH ECONOMICS LETTER

HOW MANY INFANTS LIKELY DIED IN AFRICA AS A RESULT OF THE 2008–2009 GLOBAL FINANCIAL CRISIS?

JED FRIEDMAN[a,*] and NORBERT SCHADY[b]

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ABSTRACT

The human consequences of the recent global financial crisis for the developing world are presumed to be severe, but few studies have quantified them. This letter estimates the human cost of the 2008–2009 global financial crisis in one critical dimension—infant mortality—for countries in sub-Saharan Africa. The analysis pools birth-level data, as reported in female adult retrospective birth histories from all Demographic and Health Surveys collected in sub-Saharan Africa. This results in a data set of 639,000 births to 264,000 women in 30 countries. We use regression models with flexible controls for temporal trends to assess an infant's likelihood of death as a function of fluctuations in national income. We then calculate the expected number of excess deaths by combining these estimates with growth shortfalls as a result of the crisis. The results suggest 28,000–50,000 excess infant deaths in sub-Saharan Africa in the crisis-affected year of 2009. Notably, most of these additional deaths were concentrated among girls. Policies that protect the income of poor households and that maintain critical health services during times of economic contraction may reduce the expected increase in mortality. Interventions targeted at female infants and young girls can be particularly beneficial.

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KEY WORDS: financial crisis; infant mortality; sub-Saharan Africa

Health Economics, Policy and Law, page 1 of 6
doi:10.1017/S1744133114000206

Editorial

The global financial crisis, health and health care

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SARAH GREGORY
The King's Fund, London, UK

From the early outward signs of a collapse in the US sub-prime mortgage market in the spring of 2007, the global banking crisis unfolded. Financial institutions thought too big to fail, failed. In the summer of 2007 the French bank BNP Paribas ceased activity in three hedge funds that specialized in US mortgage debt. Meanwhile, in Britain, on 14th September investors in the bank, Northern Rock, withdrew over £1 billion in the biggest run on a bank in the United Kingdom for more than a

BMJ

BMJ 2013;346:f3703 doi: 10.1136/bmj.f3703 (Published 17 June 2013)

RESEARCH

The effect of rising food prices on food consumption: systematic review with meta-regression


OPEN ACCESS

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Abstract

Objective To quantify the relation between food prices and the demand for food with specific reference to national and household income levels.

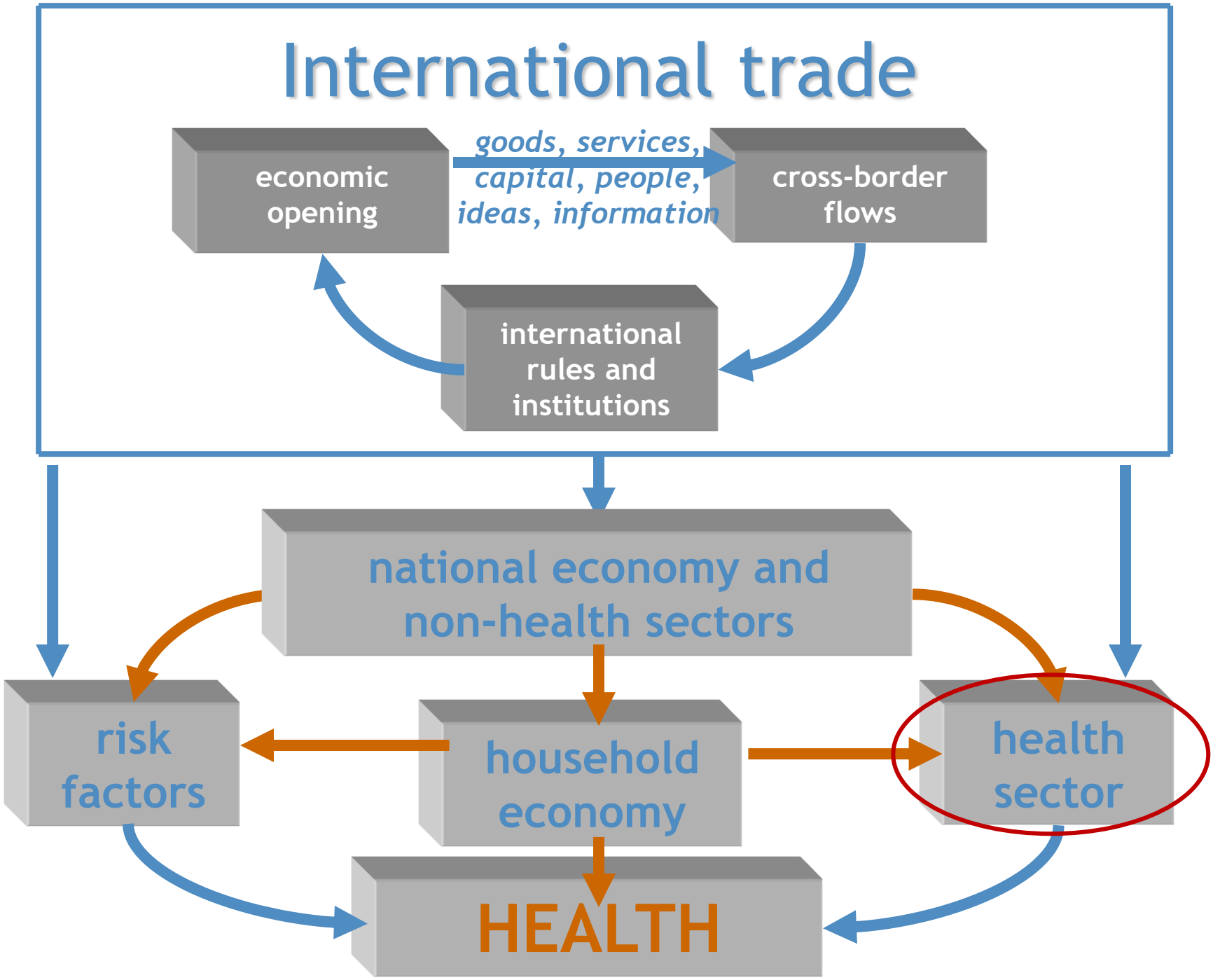
Design Systematic review with meta-regression.

Data sources Online databases of peer reviewed and grey literature (ISI Web of Science, EconLit, PubMed, Medline, AgEcon, Agricola, Google, Google Scholar, IdeasREPEC, Eldis, USAID, United Nations Food and Agriculture Organization, World Bank, International Food Policy Research Institute), hand searched reference lists, and contact with authors.

Study selection We included cross sectional, cohort, experimental, and

increase in the price of cereals results in reductions in consumption of 0.61% (95% confidence interval 0.56% to 0.66%) and 0.43% (0.36% to 0.48%), and a 1% increase in the price of meat results in reductions in consumption of 0.78% (0.73% to 0.83%) and 0.60% (0.54% to 0.66%). Within all countries, our models predict that poorer households will be the most adversely affected by increases in food prices.

Conclusions Changes in global food prices will have a greater effect on food consumption in lower income countries and in poorer households within countries. This has important implications for national responses to increases in food prices and for the definition of policies designed to reduce the global burden of undernutrition.


International trade
economic opening
goods, services, capital, people, ideas, information
cross-border flows
international rules and institutions
national economy and non-health sectors
risk factors
household economy
health sector
HEALTH

Trade and health care

- Trade in health *care* has traditionally been focused on goods – pharmaceuticals & medical devices – which can be stored and transported
- Increasingly, advances in telecommunications and travel have seen increase in trade in *services*:
  - E-health (service crosses border)
  - Foreign investment (capital crosses border)
  - Migration of health worker (supplier crosses border)
  - Medical tourism (consumer crosses border)

Medical tourism

- > 5 million foreign patients per year
- Global market > $50 billion
- Social, cultural and linguistic factors generate strong regional dimension, especially among bordering countries
  - Singapore/Malaysia patients mostly from ASEAN
  - Cuban patients mostly from Caribbean and Central America
  - Jordanian patients mostly from Yemen, Bahrain, Sudan, Syria, Libya, Palestine and Saudi Arabia

Philippines Medical Center

Live Kidney Donor Transplant in the Phlilippines

- Information about Kidney Transplants
- 24-7 private nursing
- Comfortable environment
- Contact Us

Transplant Package

The Living Donor Transplant package includes the following:

1. Transportation from the airport on the day of the arrival and to the airport on the day of departure
2. Transport, accompanying, and translation by the Company staff during all medical treatments
3. 25 days stay in a clean, respectable, and pleasant three star hotel located in the center of the city five minutes travel from the medical center including breakfast for the patient and the accompanying person of his/her choice. (The room is equipped with a television, mini-bar, and DVD.)
4. As many dialysis treatments as required
5. Hospitalization in the hospital in a large private room including television, DVD, kitchen, refrigerator, and microwave oven.
6. Living donor kidney transplant including drugs
7. Round the clock assigned nurse during the entire hospitalization
8. Anti-rejection drugs for seven days on the departure day

The total price is $85,000 USD.

The package does not include:

1. Flights
2. Medical treatments not related to the kidney transplant and disease, such as heart and other problems

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The Enterprise Centre,
6766 Ayala Ave, cor Paseo de Roxas
Macaty City 1226, Philippines
Tel: +63-2-8493953
Fax: +63-2-8865008

Noree et al. Globalization and Health 2014, 10:29
http://www.globalizationandhealth.com/content/10/1/29

GLOBALIZATION AND HEALTH

RESEARCH Open Access

UK medical tourists in Thailand: they are not who you think they are

Thinakorn Noree[1,2], Johanna Hanefeld[1,3*] and Richard Smith[1,4]

- Far smaller market than generally suggested
  - 350,000 foreign patients out of 16m tourists (250,000 of these ex-pat/opportunistic)
- MT/companions spend >twice non-MT
- No difference in care between Thais and foreigners
  - Hospitals employ spare capacity
- MT a 'good thing': add to tourism industry, but take little from domestic health system

OPEN ACCESS Freely available online

PLOS ONE

Medical Tourism: A Cost or Benefit to the NHS?

Johanna Hanefeld[1]*, Daniel Horsfall[2], Neil Lunt[2], Richard Smith[3]

1 Department Global Health and Development, Faculty of Public Health and Policy, London School of Hygiene and Tropical Medicine, London, United Kingdom, **2** Department of Social Work and Social Policy, University of York, York, United Kingdom, **3** Faculty of Public Health & Policy, London School of Hygiene & Tropical Medicine, London, United Kingdom

Abstract

'Medical Tourism' – the phenomenon of people travelling abroad to access medical treatment - has received increasing attention in academic and popular media. This paper reports findings from a study examining effect of inbound and outbound medical tourism on the UK NHS, by estimating volume of medical tourism and associated costs and benefits. A mixed methods study it includes analysis of the UK International Passenger Survey (IPS); interviews with 77 returning UK medical tourists, 63 policymakers, NHS managers and medical tourism industry actors policymakers, and a review of published literature. These informed costing of three types of treatments for which patients commonly travel abroad: fertility treatment, cosmetic and bariatric surgery. Costing of inbound tourism relied on data obtained through 28 Freedom-of-Information requests to NHS Foundation Trusts. Findings demonstrate that contrary to some popular media reports, far from being a net importer of patients, the UK is now a clear net exporter of medical travellers. In 2010, an estimated 63,000 UK residents travelled for treatment, while around 52,000 patients sought treatment in the UK. Inbound medical tourists treated as private patients within NHS facilities may be especially profitable when compared to UK private patients, yielding close to a quarter of revenue from only 7% of volume in the data examined. Costs arise where patients travel abroad and return with complications. Analysis also indicates possible savings especially in future health care and social costs averted. These are likely to be specific to procedures and conditions treated. UK medical tourism is a growing phenomenon that presents risks and opportunities to the NHS. To fully understand its implications and guide policy on issues such as NHS global activities and patient safety will require investment in further research and monitoring. Results point to likely impact of medical tourism in other universal public health systems.

Research

BMJ Global Health

Achieving universal health coverage in small island states: could importing health services provide a solution?

Mariyam Suzana,[1] Helen Walls,[2] Richard Smith,[2] Johanna Hanefeld[2]

Suzana *et al. Globalization and Health* (2018) 14:58
https://doi.org/10.1186/s12992-018-0375-4

Globalization and Health

RESEARCH Open Access

Understanding medical travel from a source country perspective: a cross sectional study of the experiences of medical travelers from the Maldives

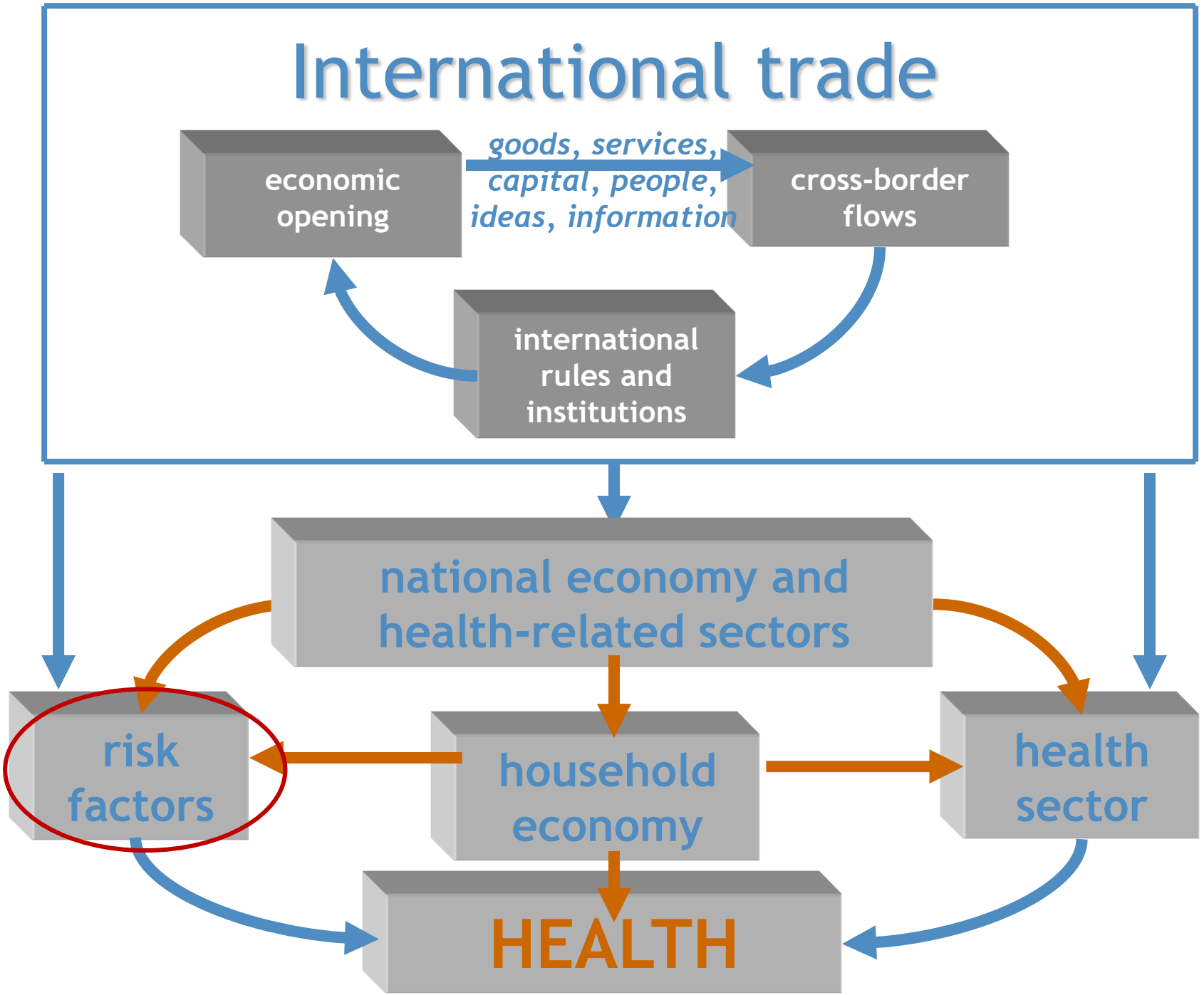
Mariyam Suzana[1*], Helen Walls[2], Richard Smith[2] and Johanna Hanefeld[2]

International Journal for Equity in Health

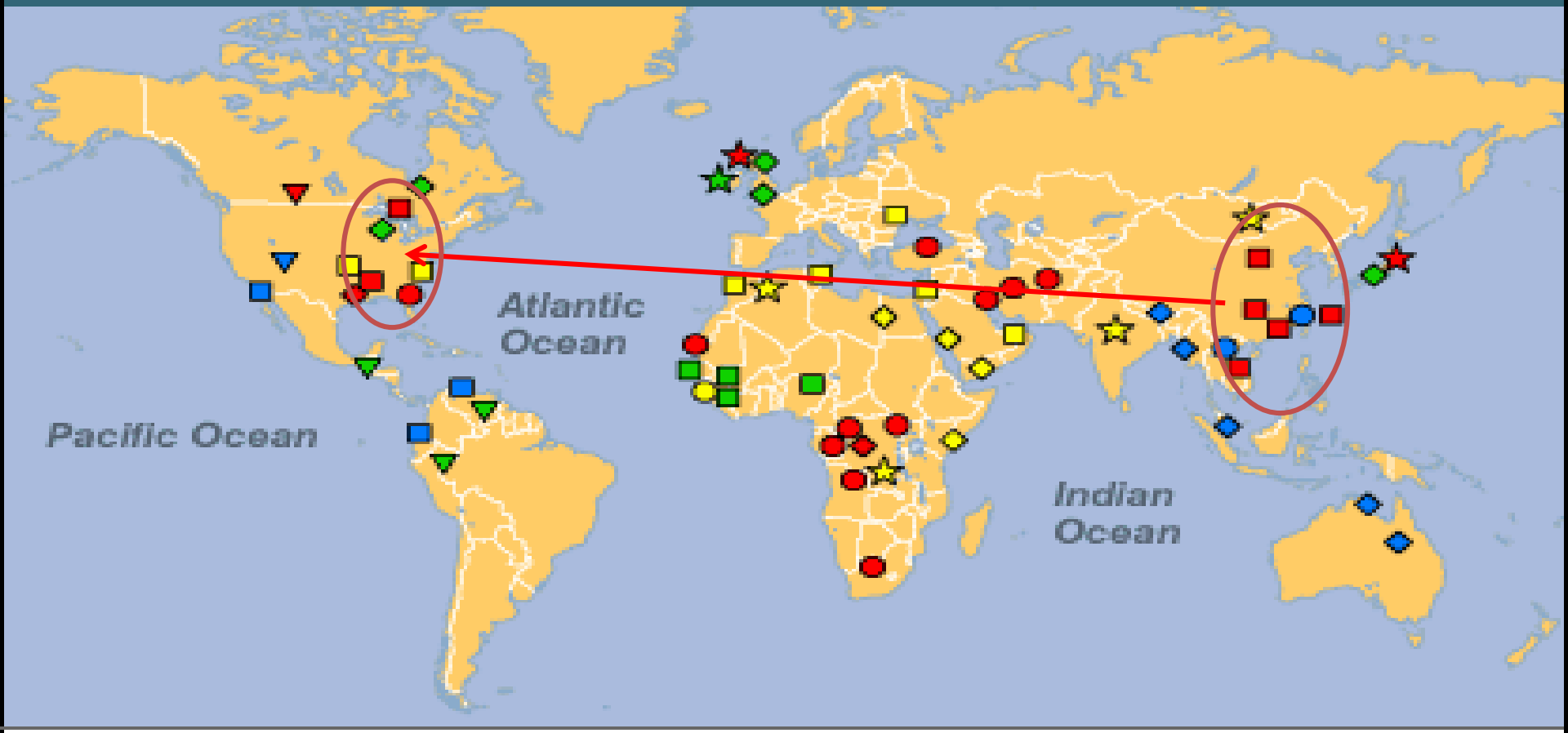
RESEARCH Open Access

Evaluation of public subsidy for medical travel: does it protect against household impoverishment?

Mariyam Suzana[1*], Helen Walls[2], Richard Smith[2] and Johanna Hanefeld[2]


International trade
economic opening
goods, services, capital, people, ideas, information
cross-border flows
international rules and institutions
national economy and health-related sectors
risk factors
household economy
health sector
HEALTH

EMERGING AND RE-EMERGING INFECTIOUS DISEASES: 1996-2004

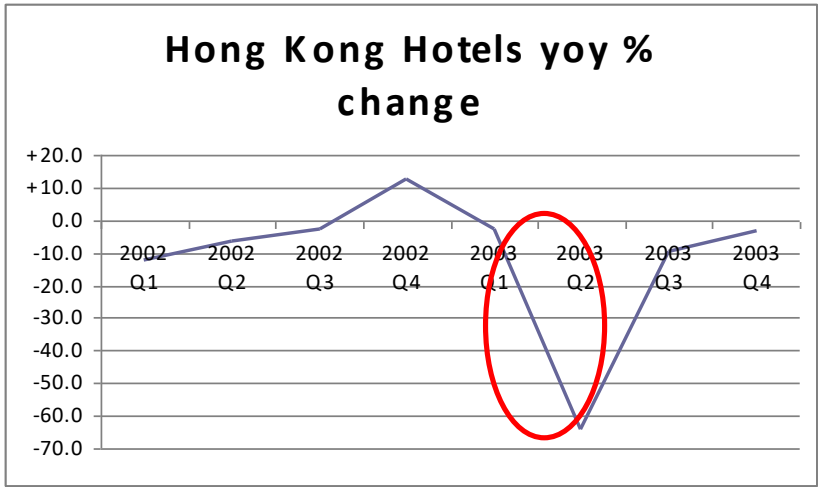


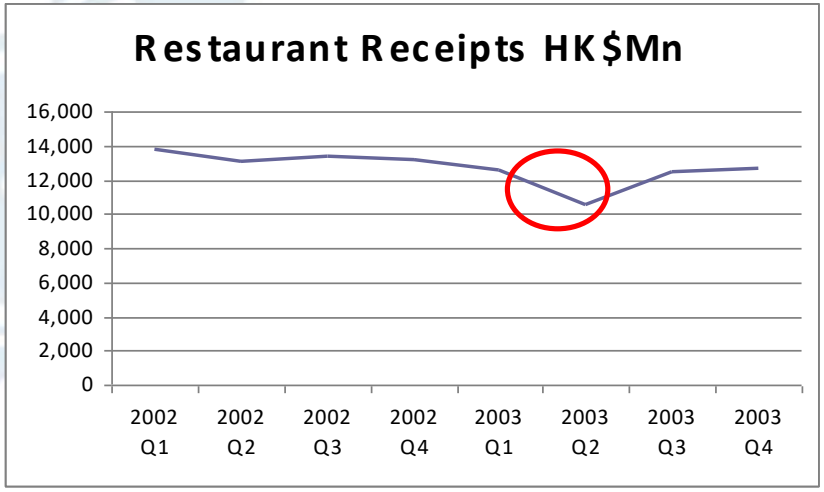
- Ebola and Crimean Congo haemorrhagic fever
- Influenza H5N1
- Lassa fever
- Monkeypox
- Nipah Hendra
- Riftvalley fever
- New variant Creutzfeld-Jakob disease
- SARS coronavirus
- Venezuelan equine encephalomyelitis
- Yellow fever
- West Nile fever
- Cryptosporidiosis
- Leptospirosis
- Lyme borreliosis
- Escherichia coli 0157
- Multidrug-resistant Salmonella
- Plague

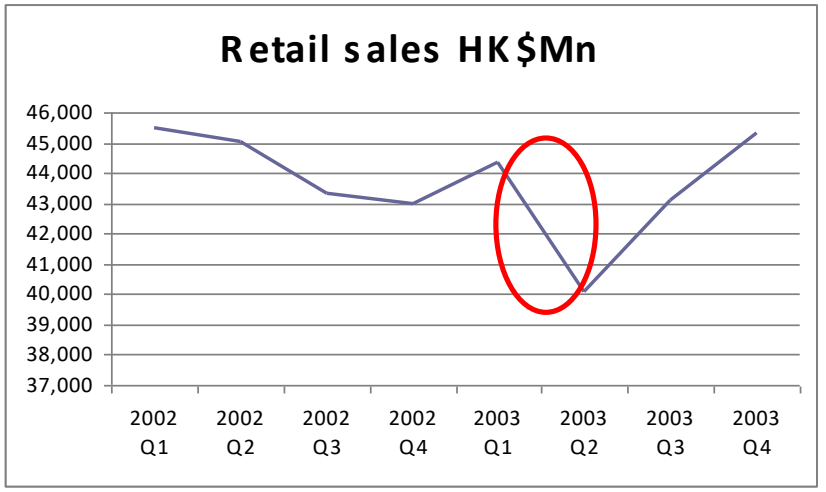
SOURCE: WHO

SARS in Hong Kong

- Health (sector) impact small, but impact on other sectors large
  - E.g. Hong Kong retail losses ~ US$334m







Epidemics damage economies as well as health

Aug 16th 2014 | LAGOS AND LONDON | From the print edition

The Economist

Timekeeper

Keep calm and carry on

ONE of the first casualties of any epidemic is tourism. The outbreak of Ebola in west Africa provides the latest evidence. "The Ebola scare is really affecting bookings," says Darren Julyse, a manager with a boutique hotel group in Lagos, Nigeria's largest city and its commercial capital. "A lot of big companies are putting on travel restrictions."


TIME
CDC'S SMARTS PREVENTING MONDAY'S WOES
The Flu Hunters
Follow the trail of scientific detectives who are trying to stop a lethal virus—before it spreads around the world


nature
AVIAN FLU

BMJ

RESEARCH

The economy-wide impact of pandemic influenza on the UK: a computable general equilibrium modelling experiment

Richard D Smith, professor of health system economics,[1] Marcus R Keogh-Brown, research fellow in economic modelling,[1] Tony Barnett, professorial research fellow and honorary professor,[1,2] Joyce Tait, professor and scientific adviser[3]

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Cite this as: *BMJ* 2009;339:b4571
doi:10.1136/bmj.b4571

ABSTRACT

Objectives To estimate the potential economic impact of pandemic influenza, associated behavioural responses, school closures, and vaccination on the United Kingdom.

Design A computable general equilibrium model of the UK economy was specified for various combinations of mortality and morbidity from pandemic influenza, vaccine efficacy, school closures, and prophylactic absenteeism using published data.

Setting The 2004 UK economy (the most up to date available with suitable economic data).

Main outcome measures The economic impact of various scenarios with different pandemic severity, vaccination, school closure, and prophylactic absenteeism specified in terms of gross domestic product, output from different economic sectors, and equivalent variation.

Results The costs related to illness alone ranged between 0.5% and 1.0% of gross domestic product (£8.4bn to £16.8bn) for low fatality scenarios, 3.3% and 4.3% (£55.5bn to £72.3bn) for high fatality scenarios, and

syndrome (2003), H1N1 subtype of the influenza A virus (2009), and sporadic outbreaks of H5N1 influenza subtype.[2] In addition to the direct health impacts of a serious outbreak, we should be concerned about the economic impact; especially at a time of global recession.[3] Preparedness planning for a pandemic must therefore balance two key policy strands—maintaining "business as usual" to minimise the economic impact of a pandemic, and encouraging "social distancing" to minimise the health related impact of a pandemic[4]—as well as using resources such as antivirals and vaccinations.

This paper considers the tension inherent in these two policy strands. It provides evidence of the economy-wide impact of each approach, as well as the impact that vaccine development may have in reconciling the two objectives of minimising both the health and economic effects of a pandemic. A key consideration in this analysis is the role of public perception and confidence, expressed by "prophylactic absenteeism,"

HEALTH ECONOMICS
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Published online 19 July 2012 in Wiley Online Library (wileyonlinelibrary.com). DOI: 10.1002/hec.2862

THE ECONOMIC IMPACT OF H1N1 ON MEXICO'S TOURIST AND PORK SECTORS

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Department of Global Health and Development, Faculty of Public Health and Policy, London School of Hygiene and Tropical Medicine, London, UK

SUMMARY

By examining tourist arrivals and pork output and trade statistics, this analysis estimates the economic impact to the Mexican tourism and pork sectors because of the H1N1 influenza pandemic. It also assesses the role of the international response in the context of this economic impact.

For tourism, losing almost a million overseas visitors translated into losses of around $US2.8bn, which extended over a five-month period, mostly because of the slow return of European travellers. For the pork industry, temporal decreases in output were observed in most of the country and related to H1N1 incidence ($p = 0.048$, $r = 0.37$). By the end of 2009, Mexico had a pork trade deficit of $US27m. The losses derived from this pandemic were clearly influenced by the risk perception created in tourist-supplying and pork trade partners.

Results suggest that the wider economic implications of health-related emergencies can be significant and need to be considered in preparedness planning. For instance, more effective surveillance and data gathering would enable policy to target emergency funding to the sectors and regions hardest hit. These results also stress the importance of being familiar with trade networks so as to be able to anticipate the international response and respond accordingly.

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GLOBAL HEALTH

Global Noncommunicable Diseases — Where Worlds Meet

K.M. Venkat Narayan, M.D., Mohammed K. Ali, M.B., Ch.B., and Jeffrey P. Koplan, M.D., M.P.H.

Like climate change, the relentless worldwide spread of noncommunicable diseases offers an opportunity for low-, middle-, and high-income countries to join forces in addressing a major global challenge that threatens health and economies alike. A recent report from the World Health Organization[1] identified six risk factors associated with noncommunicable diseases as the leading global risk factors for death: high blood pressure, tobacco use, high blood glucose levels, physical inactivity, overweight or obesity, and high cholesterol levels. Together, these factors contribute to a large proportion of

situations of individuals, families, and societies. According to the World Economic Forum's 2009 report, noncommunicable diseases are among the most severe threats to global economic development, more likely to be realized and potentially more detrimental than fiscal crises, natural disasters, or pandemic influenza. It is projected that in the next 10 years, China, India, and Britain will lose $558 billion, $237 billion, and $33 billion, respectively, in national income as a result of largely preventable heart disease, strokes, and diabetes.[2,3] In the United States, cardiovascular disease and diabetes

culosis and community-acquired pneumonias — and therefore to the poorer outcomes associated with these complications. Furthermore, owing to burdensome health care costs, disability, absenteeism, and forgone income, noncommunicable diseases result in poverty, thus contributing to a vicious cycle. Because of their multiple interacting causes and complications, as well as their lifelong nature, noncommunicable diseases challenge current paradigms of health care organization and delivery.

Confronted by the ever-increasing threat of such diseases, high-, middle- and low-income coun-

Chronic Diseases: Chronic Diseases and Development 2

Health, agricultural, and economic effects of adoption of healthy diet recommendations

Karen Lock, Richard D Smith, Alan D Dangour, Marcus Keogh-Brown, Gessuir Pigatto, Corinna Hawkes, Regina Mara Fisberg, Zaid Chalabi

Transition to diets that are high in saturated fat and sugar has caused a global public health concern, as the pattern of food consumption is a major modifiable risk factor for chronic non-communicable diseases. Although agri-food systems are intimately associated with this transition, agriculture and health sectors are largely disconnected in their priorities, policy, and analysis, with neither side considering the complex inter-relation between agri-trade, patterns of food consumption, health, and development. We show the importance of connection of these perspectives through estimation of the effect of adopting a healthy diet on population health, agricultural production, trade, the economy, and livelihoods, with a computable general equilibrium approach. On the basis of case-studies from the UK and Brazil, we suggest that benefits of a healthy diet policy will vary substantially between different populations, not only because of population dietary intake but also because of agricultural production, trade, and other economic factors.

Lancet 2010; 376: 1699–709

Published Online November 11, 2010 DOI:10.1016/S0140-6736(10)61352-9

See Comment page 1619

See Online/Comment DOI:10.1016/S0140-6736(10)61856-9, and DOI:10.1016/S0140-6736(10)61891-0

This is the second in a Series of five papers about chronic diseases

London School of Hygiene and Tropical Medicine, and Leverhulme Centre for Integrative Research on Agriculture and Health, London, UK (K Lock PhD, Prof R D Smith PhD, A D Dangour PhD, M Keogh-Brown PhD, Z Chalabi PhD); **Universidade Estadual Paulista Julio de Mesquita Filho, Tupã, Brazil** (G Pigatto PhD); **and Faculty of Public Health, University of São Paulo, São Paulo, Brazil** (C Hawkes PhD, R M Fisberg PhD)

Introduction

Profound inequalities in access to food exist between the 1 billion people worldwide who are estimated to be undernourished and the many millions who have over-abundant access to diets that are rich in calories but low in mineral and vitamin density.[1] Concurrently, a transition to diets high in saturated fat (mainly meat and dairy foodstuffs) and sugar, and low in staple foods such as cereals, fruits, and vegetables, is occurring in all but the very poorest of countries.[2,3] This transition is causing global public health concern, because patterns of food consumption are a major modifiable risk factor for three of the most common types of chronic non-communicable diseases: cardiovascular disease, diabetes, and some cancers.[4]

Six risk factors related to nutrition (including high blood pressure, high blood glucose, overweight, and obesity)

foods. Indeed, agricultural and health sectors are largely disconnected in their priorities and policy objectives. Typically, agricultural priorities centre on production and processing systems, markets, and livelihoods, with concern for food safety only as it affects trade, rather than on broad public health issues. By contrast, public health traditionally centres on agriculture insofar as it affects food security and food safety, with only recent consideration of agriculture's potential role in prevention of non-communicable diseases.[7,10] Neither sector considers the complex inter-relation between agri-trade, food consumption patterns, health, and development.[11,12]

Reduction of the burden of chronic disease through consumption of healthier diets than are consumed at present will probably benefit the health of millions of people, especially the poorest. However, such improvement

Schram et al. Globalization and Health (2015) 11:41
DOI 10.1186/s12992-015-0127-7

GLOBALIZATION AND HEALTH

RESEARCH Open Access

The role of trade and investment liberalization in the sugar-sweetened carbonated beverages market: a natural experiment contrasting Vietnam and the Philippines

Ashley Schram[1*], Ronald Labonte[1], Phillip Baker[2], Sharon Friel[2], Aaron Reeves[3] and David Stuckler[3]

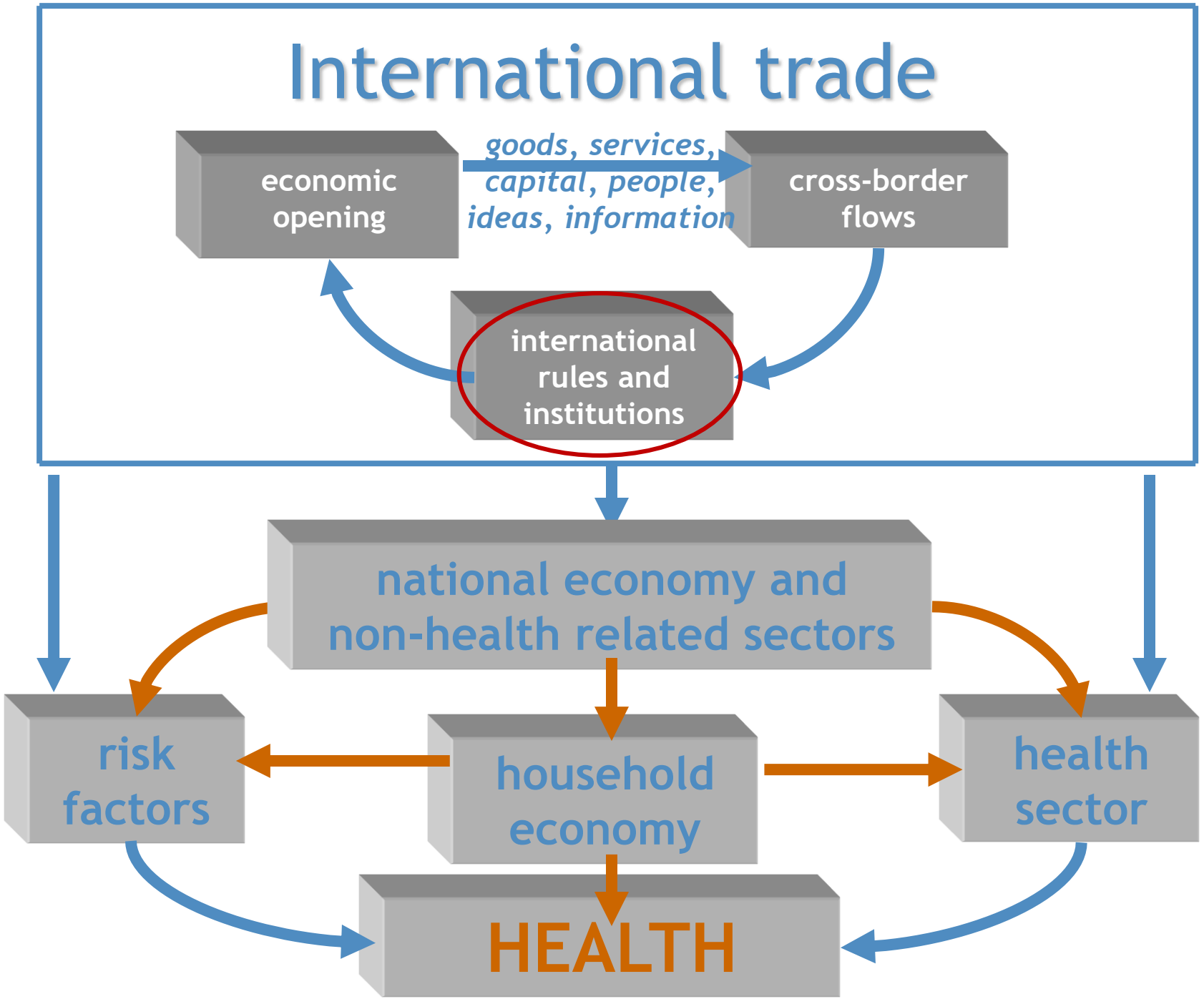
Abstract

Background: Trade and investment liberalization may facilitate the spread of sugar-sweetened carbonated beverages (SSCBs), products associated with increased risk factors for obesity, type II diabetes, and cardiovascular diseases (Circulation 121:1356–1364, 2010). Apart from a limited set of comparative cross-national studies, the majority of analyses linking liberalization and the food environment have drawn on case studies and descriptive accounts. The current failure of many countries to reverse the obesity epidemic calls for investigation into both individual and systemic factors, including trade and investment policies.

Methods: Using a natural experimental design we tested whether Vietnam's removal of restrictions on foreign direct investment (FDI) subsequent to its accession to the World Trade Organization in 2007 increased sales of SSCBs compared with a matched country, the Philippines, which acceded in 1995. Difference-in-difference (DID) models were used to test pre/post differences in total SSCB sales and foreign company penetration covering the years 1999–2013.

Results: Following Vietnam's removal of restrictions on FDI, the growth rate of SSCB sales increased to 12.1 % per capita per year from a prior growth rate of 3.3 %. SSCB sales per capita rose significantly faster pre- and post-intervention in Vietnam compared with the control country the Philippines (DID: 4.6 L per annum, 95 % CI: 3.8 to 5.4 L, $p < 0.008$). Vietnam's increase in SSCBs was primarily attributable to products manufactured by foreign companies, whose annual sales growth rates rose from 6.7 to 23.1 %, again unmatched within the Philippines over this period (DID: 12.3 %, 95 % CI: 8.6 to 16.0 %, $p < 0.049$).

Conclusions: Growth of SSCB sales in Vietnam, led by foreign-owned companies, significantly accelerated after trade and investment liberalization.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national economy and non-health related sectors
risk factors
household economy
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World Trade Organization

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

WTO and health

HEALTH ISSUES	WTO RULES			
	SPS	TBT	TRIPS	GATS
• Infectious disease control	*	*		
• Food safety	*			
• Tobacco control		*	*	*
• Environment	*	*		
• Access to drugs			*	
• Health services				*
• Food security	*			
Emerging issues				
• Biotechnology	*	*	*	
• Information Technology			*	
• Traditional knowledge			*	

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- Feature: How market based pricing is failing Indian patients (*BMJ* 2014;348:g278)
- Personal view: India's rejection of Novartis's patent is but a small step in the right direction (*BMJ* 2013;346:f2412)

Patent wars: affordable medicines versus intellectual property rights

In the battle for affordable medicine India has delivered several blows to the drug industry. **Jacqui Wise** reports on how India has inspired other developing countries to challenge the patent system

The pharmaceutical industry is increasingly looking towards emerging markets, where demand for new drugs is rising rapidly alongside rates of chronic disease. But in recent years India, known as the "pharmacy of the developing world," has led the battle for affordable drugs, using legal mechanisms to overturn patents so that its generic drug companies (which produce a fifth of the world's generic drugs) can undercut the Western giants. Developing countries have followed India's example, and battles over patent protection and prices have broken out from

INDIA'S FIGHT FOR AFFORDABLE DRUGS

2001: The Doha declaration on trade related aspects of intellectual property rights (TRIPS) and public health reaffirmed the right to balance public health needs with intellectual property rights

2001: Indian generic company Cipla begins marketing a $1 a day generic combination antiretroviral therapy

2005: India signs the World Trade Organization's TRIPS agreement, which includes a 20 year patent term for medicines

March 2012: India awards first compulsory licence for a generic version of Bayer's cancer drug sorafenib (Nexavar)

April 2013: Indian Supreme Court rules against Novartis, ending seven year battle to patent an updated version of leukaemia drug imatinib

May 2013: India put on the Office of the US Trade Representative's priority watch list

August 2013: Roche decides not to pursue its patent on trastuzumab (Herceptin)

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Implications of the World Trade Organization in combating non-communicable diseases

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SUMMARY

The World Health Organization (WHO) has proposed a number of strategies to combat non-communicable diseases such as cancers, cardiovascular diseases, chronic respiratory diseases and diabetes by targeting the risk factors of tobacco use, harmful use of alcohol and poor diet. A number of the domestic regulatory responses contemplated by WHO and individual countries have the potential to restrict or distort trade, raising the question of whether they are consistent with the obligations imposed on Members of the World Trade Organization (WTO). This article demonstrates that WTO rules do limit Members' flexibility in implementing public health measures to address these diseases. However, the focus of WTO provisions on preventing discrimination against or between imports and the exceptions incorporated in various WTO agreements leave sufficient scope for Members to design carefully directed measures to achieve genuine public health goals while minimizing negative effects on international trade.

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The vulnerability of being ill informed: the Trans-Pacific Partnership Agreement and Global Public Health

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Will the next generation of preferential trade and investment agreements undermine prevention of noncommunicable diseases? A prospective policy analysis of the Trans Pacific Partnership Agreement

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How much priority is given to nutrition and health in the EU Common Agricultural Policy?

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ABSTRACT

Agriculture in the European Union (EU) is strongly influenced by the Common Agricultural Policy (CAP). There have been repeated calls for CAP to address nutrition-related health, particularly obesity and non-communicable disease (NCD) in the EU. However, aligning agricultural policy such as CAP with nutrition is complex, not least because the aims of agricultural policy are predominantly economic, presenting a challenge for developing coherence between agricultural trade and health policy. This research examined the political priority given to nutrition-related health concerns within CAP to date, and the solutions suggested by agricultural, trade and health policy-makers and public health nutrition advocates, via interviews of 20 high-level participants from respective sectors. The participants provided diverse perspectives, often varying by sector and institution, on the connections between agricultural policy and nutrition-related health, the extent to which nutrition concerns have been addressed via CAP and whether CAP is an appropriate and effective policy approach to improve nutrition-related health in the EU in the future. The key findings suggest the need for communication and agreement of clear high-level nutrition guidelines, clarity on the EU mandate to address nutrition-related health concerns via policy, and stronger engagement of civil society in the issues if CAP is to address nutrition more than it is doing currently. The difference in worldviews between agricultural/trade representatives, and those from public health, also needs to be addressed.

ANALYSIS

Liberalising agricultural policy for sugar in Europe risks damaging public health

Emilie Aguirre and colleagues discuss what changes to Europe's agricultural policy might mean for our health

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Key messages

- Reforms to the common agriculture policy will lower the commodity price of sugar and liberalise production of high fructose corn syrup in 2017
- These changes have the potential to increase sugar consumption, particularly among the lowest socioeconomic groups
- Europe must explore short to medium term responses to the projected increase of sugars in the food supply such as mandatory reformulation targets and improved monitoring of food content, diet, and health
- In the longer term we should ensure that agricultural policies promote a healthier diet

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

EDITORIAL

Brexit's Great Repeal Bill will axe the right to health

Essential protections will be lost if government plans go ahead

The fundamental right to health in the UK will be lost if the government proceeds with its plan not to convert the EU Charter of Fundamental Rights[1] into UK law, as announced in the white paper on the Great Repeal Bill.[2]

The value of this charter was shown last year, in both EU[3] and UK[4] courts, when the tobacco industry unsuccessfully challenged the new rules on plain packaging of cigarettes.[5 6] One of the industry's

and air and water quality. The change will considerably weaken the ability of judges in future to uphold the law if it is challenged by industry in the courts.

The government puts forward two arguments to support its intention to dispense with the charter. The first is that because the charter applies only when the UK is acting within the scope of EU law "its relevance is removed by [Brexit]." This is a technical point that ignores the serious implications of the change.

The value of the EU charter was shown last year, when the tobacco industry unsuccessfully challenged the new rules on plain packaging of cigarettes

the ECHR, including, for example, the right to an effective remedy and fair trial, and to same sex marriage.

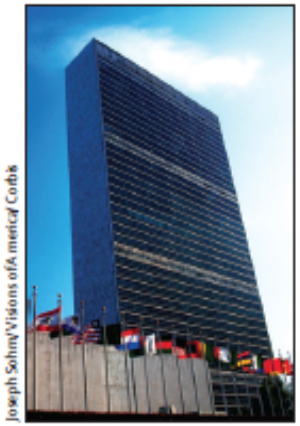
Health policy challenge

- Increasingly health (care) affected by events beyond boundaries/control: wider economy, health-specific trade, disease risk-factors etc
  - Requires greater involvement from health (economists) in *economic* (trade) policy making
  - And design of proactive *health* policy
- Greater emphasis on economic and trade case for/against initiatives that affect health (care):
  - swing agenda/mobilise resources
  - identify our allies and our enemies!

Trade over health....

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

What can the UN General Assembly do for global health?



Joseph Sohm/Visions of America/Corbis

See Comment pages 1001, 1002, 1005, and 1006

See Articles page 1029

See Review page 1049

5 years ago the most important international event in global health was still the World Health Assembly, held in Geneva each May. At that gathering, Ministers of Health meet and decide global priorities and strategies for improving the health and wellbeing of their peoples. WHO visibly expresses and demonstrates its leadership at the Assembly, with technical staff guiding ministers in their decision-making and planning. The Assembly is the platform from which global health's supreme inter-governmental authority—WHO's Director-General—speaks to the world about its collective successes, challenges, and opportunities. But that week in May has now been eclipsed by a gathering with even greater political weight: the UN General Assembly (UNGA), held in New York next week.

Why has New York superseded Geneva? The UNGA is where Heads of State, not merely Ministers of Health, gather. It is sadly true that most health ministers lack domestic political muscle. They might talk tough among themselves, but back home they have to get in line behind colleagues in finance, defence, trade, and even education. In New York, if a Head of State chooses to lead his or her delegation on a health topic, others stop, listen, and pay attention. In New York next week, Prime Minister Shinzo Abe of Japan will lead on Universal Health Coverage. Prime Minister Stephen Harper of Canada and President Jakaya Kikwete of Tanzania will lead on women's and children's health. They will get the kind of attention and audience their health ministers can only dream about.

New York also matters because this is where an increasing number of critical reports are published and debated among policy makers, agencies, and politicians. For example, UNICEF uses the UNGA to publish and disseminate its latest numbers for child mortality, thereby drawing maximum high-level political attention to child survival. Indeed, it is at the UNGA where the future of the post-2015 agenda will be forged. The General Assembly is now an event that cannot be ignored by the health community. Keep an eye on New York next week. Interesting things are likely to happen. ■ *The Lancet*

THE LANCET

Trade and Health · January, 2009 www.thelancet.com

"The fact that trade directly and indirectly affects the health of the global population with an unrivalled reach and depth undoubtedly makes it a key health issue that the global health economics community can no longer ignore."