Global trade, public health, and health services: Stakeholders’ constructions of the key issues

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Abstract

Focusing mainly on the United States and Latin America, we aimed to identify the constructions of social reality held by the major stakeholders participating in policy debates about global trade, public health, and health services. In a multi-method, qualitative design, we used three sources of data: research and archival literature, 1980–2004; interviews with key informants who represented major organizations participating in these debates, 2002–2004; and organizational reports, 1980–2004. We targeted several types of organizations: government agencies, international financial institutions (IFIs) and trade organizations, international health organizations, multinational corporations, and advocacy groups. Many governments in Latin America define health as a right and health services as a public good. Thus, the government bears responsibility for that right. In contrast, the US government’s philosophy of free trade and promoting a market economy assumes that by expanding the private sector, improved economic conditions will improve overall health with a minimum government provision of health care. US government agencies also view promotion of global health as a means to serve US interests. IFIs have emphasized reforms that include reduction and privatization of public sector services. International health organizations have tended to adopt the policy perspectives of IFIs and trade organizations. Advocacy groups have emphasized the deleterious effects of international trade agreements on public health and health services. Organizational stakeholders hold widely divergent constructions of reality regarding trade, public health, and health services. Social constructions concerning trade and health reflect broad ideologies concerning the impacts of market processes. Such constructions manifest features of “creed,” regarding the role of the market in advancing human purposes and meeting human needs. Differences in constructions of trade and health constrain policies to address the profound changes generated by global trade.

Keywords: Global trade; Public health; International financial institutions; Multinational corporations; International health organizations; United states; Latin America

Introduction

Globalization has emerged as a highly debated arena of general social policy, both in the United States and internationally. However, the relationships among global trade, public health, and health services remain poorly understood. In this study, we aimed to assess the attitudes, decisions, and actions of major groups participating in policy debates about globalization, public health, and health services: government agencies, international financial and trade organizations, international health organizations, multinational corporations

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(MNCs), and advocacy groups. Our research used the following definition: globalization is the process by which interconnected economic transactions increasingly occur throughout the world, facilitated by (a) international agreements that encourage deregulated “free trade”; (b) management of trade by international trade organizations and banks; (c) expanded investment, sales, and collaborations by MNCs; (d) increased movement of private finance capital across national boundaries; and (e) privatization of enterprises previously administered in the public sector.

The study, which extended a previous direction of research on economic globalization in the United States and Latin America (Stocker, Waitzkin, & Iriart, 1999; Iriart, Merhy, & Waitzkin, 2001; Jasso-Aguilar, Waitzkin, & Landwehr, 2004), addressed the following research questions:

- How do US government agencies’ policies regarding trade, public health, and health services resemble or differ from those for foreign countries, especially Latin American countries?
- What are the attitudes, decisions, and actions expressed by representatives of several types of organizations regarding public health and health services: international financial institutions (IFIs) and trade organizations; international health organizations; MNCs; and organized groups of consumers, professionals, non-professional workers, and environmentalists?

To contextualize this project: Before we began the research, we participated in several networks of professionals and activists concerned about the impact of global trade on public health and health services. From that work, we perceived that key individuals and the institutions they represented manifested widely divergent views about the same empirical reality. In short, we noted varying social constructions of core issues linking trade and health, often related to the economic and political interests of major organizational stakeholders in policies concerning trade (Berger & Luckmann, 1966; Edelman, 1985, 1988, 2001). That is, the ideas that motivated action and policy decisions seemed to derive from socially constructed visions of the relationships among global trade, public health, and health services. Such constructions appeared to vary, depending on the institutional interests and ideologies of the protagonists. Surprisingly, we observed that economic motivations such as profit maximization arose rarely in discourses on trade and health, even those enunciated by leaders of MNCs and IFIs. Instead, we noted that visions of favorable or unfavorable effects of trade on health reflected more general assumptions about how market forces affect health and well-being.

We undertook this research to clarify protagonists’ constructions of the social realities linking trade and health. By this work, in addition to the usual intellectual goal of deeper understanding, we hoped to make a practical contribution to policy debates and decisions in this crucial arena.

**Background**

The process of globalization raises several issues regarding health care, public health, and health services. Influenced by policy makers in the United States, the structural adjustment programs imposed by organizations such as the World Bank, International Monetary Fund (IMF), and World Trade Organization (WTO) have implemented “neoliberal” policies requiring reduction and privatization of services previously provided in the public sector, as a condition for new or renegotiated loans (World Bank, 1993; Stocker et al., 1999; Iriart et al., 2001; Waitzkin, 2003; Rao, 1999; Turshen, 1999).

In addition to these non-commercial organizations, MNCs have expanded worldwide. Managed care organizations (MCOs), health care consulting firms, and pharmaceutical and medical equipment companies have entered foreign markets (Stock et al., 1999; Iriart et al., 2001). US industrial corporations also have operated in foreign countries; the participation of workers and the promotion of products in those countries have raised concerns about the impacts on local economies, environmental health, and occupational health (McMichael & Beaglehole, 2000). The “flight” of MNCs to foreign sites with less costly labor and environmental regulations has led to unemployment and loss of health insurance benefits for US workers (Kim, Millen, Irwin, & Gershman, 2000). During the late 1990s, MCOs faced declining rates of profit in US markets. The MCOs then entered foreign markets seeking access to public social security funds designated for health care and retirement benefits (Stock et al., 1999). When MCOs shifted their focus to foreign public trust funds as a source of new capital, they tended to withdraw from US Medicare and Medicaid markets, with consequent disruption of services for patients (Lankarge, 2003).

International trade agreements facilitate economic globalization and have exerted increasing effects on policies pertinent to public health and health services. The framework for such agreements began with the “Bretton Woods” accords, which sought to enhance the post-war economies of Western Europe. Between 1944 and 1947, Bretton Woods led to the creation of the IMF, World Bank, and General Agreement on Tariffs and Trade (GATT). GATT reduced tariffs and other barriers to international trade. During the 1980s and 1990s, while the World Bank and IMF enforced the
large debt burdens of Third World countries, changes in GATT provided less regulated access to labor, national markets, and natural resources (Kim et al., 2000).

Established in 1994 after the “Uruguay round” of GATT meetings, WTO has sought to consolidate international agreements, with a goal of removing barriers to trade. WTO procedures generally treat trade relationships solely as a business issue and restrict consideration of related issues, including social, environmental, and health problems. Since WTO requires that laws of member nations must conform to its rules, WTO exerts major influence over national and sub-national laws that could be seen as trade barriers. Sanctions against member nations that do not comply with WTO rules can exert major economic and social effects. In addition to tariffs, WTO agreements pertain to many policy arenas with direct or indirect implications for health policy.

Although WTO (2003, under General Exceptions of GATT, Article XX) permits national or subnational “measures to protect human, animal or plant life or health,” WTO has initiated sanctions or informal pressures to restrict such protective measures when they interfere with international trade. Increasingly, regional or bilateral trade agreements modeled according to WTO provisions, such as the North American Free Trade Agreement (NAFTA) and the Free Trade Area of the Americas (FTAA), have affected public health and health services. Table 1 provides an overview of the impacts of these agreements on public health and health services, which we and others have analyzed elsewhere from differing perspectives (Shaffer, Waitzkin, Jasso-Aguilar, & Brenner, 2005; Pollock & Price, 2000, 2003; Ranson et al., 2002; Adlung & Carzaniga, 2001).

The processes by which policies pertinent to public health and health services change in response to globalization have remained largely silent—little noticed or debated in legislative bodies or in the public media. From our prior research on the exportation of managed care to Latin America, we have found that policy decisions and their implementation generally occur through executive decrees and changes in regulatory processes (Stocker et al., 1999; Iriart et al., 2001). Professional associations and consumer organizations often do not learn of the changes early enough to affect them. Health policy changes inherent in globalization likewise have received scant attention in legislative bodies.

Global trade policies have generated opposition among groups representing consumers, health care professionals, non-professional workers, and environmentalists. This opposition has led to widely publicized protests in Seattle, Washington, Prague, Genoa, Cancún, Miami, and elsewhere. However, the pertinence of these critiques for public health and health services remains to be clarified.

Methods

We used a multi-method design, which involved data collection from three sources. First, we reviewed the research and archival literature on global trade, public health, and health services. This method, adapted from our prior investigations, began with a structured study of publications and unpublished literature. We examined professional journals, business journals, newspapers and magazines, government documents, legislative materials and hearing dockets, and corporate records in the public sphere. In addition, we searched databases in medicine and health policy, business, government, and the social sciences to locate pertinent articles from 1980 to 2004 and assessed the internet web sites of government agencies, multinational banking and trade organizations, international and national health organizations, MNCs, and advocacy groups. We searched these databases and indexes for keywords including but not limited to: health care, health policy, public health, international, global, globalization, trade, privatization, managed care, and management. The targeted organizations and trade agreements were searched as keywords, authors, and title words.

Second, we conducted interviews with representatives of these same organizations. These key informant interviews were conducted in person, by telephone, and/or by electronic mail with a semi-structured protocol, designed to elicit responses concerning globalization and health policy. In-person interviews occurred during research visits to Washington, DC, New York City, Philadelphia, San Francisco, Guadalajara (Mexico), Mexico City (Mexico), Cuernavaca (Mexico), Buenos Aires (Argentina), Brasilia (Brazil), and Geneva (Switzerland). Telephone and e-mail interviews also included respondents in Massachusetts, Colorado, and the United Kingdom.

As key informants, we selected representatives in each targeted type of organization. As recommended by methodological guidelines for qualitative research, we continued to recruit respondents for in-depth interviews until the responses became redundant and additional information or viewpoints were not elicited (Schensul, Schensul, & LeCompte, 1999). By this criterion, we conducted 42 interviews. For these interviews, we used a standardized protocol of close-ended and open-ended items. If permitted by respondents, the interviews were recorded, and pertinent passages were transcribed. Human subjects provisions were approved by the University of New Mexico Institutional Review Board.

Third, we assessed the organizations’ annual or other periodic reports that were available in the public sphere. Most of the organizations publish reports in printed form and/or on their web sites. In many instances, these reports are prepared for investors. In other cases, the
Table 1
Summary of international trade agreements and organizations pertinent to public health

<table>
<thead>
<tr>
<th>Treaty or organization</th>
<th>Focus</th>
<th>Ratification or negotiation status</th>
<th>Examples of cases pertinent to public health</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Agreement on Trade and Tariffs (GATT)</td>
<td>Part of Bretton Woods accords at end of World War II; reduced tariffs as financial barrier to trade.</td>
<td>Applies to all 148 nations that now participate in WTO.</td>
<td>Venezuela won a challenge to US Clean Air Act of 1990; the decision weakened regulation of gasoline contaminants that contribute to pollution.</td>
</tr>
<tr>
<td>World Trade Organization (WTO)</td>
<td>Emerged in 1994 from the &quot;Uruguay Round&quot; of GATT negotiations. Created a stable organization with staff. Aims to remove tariff and non-tariff barriers to trade.</td>
<td>Includes all WTO member nations.</td>
<td>See below under separate trade agreements.</td>
</tr>
<tr>
<td>North American Free Trade Agreement (NAFTA)</td>
<td>Removed most restrictions on trade among the United States, Canada, and Mexico.</td>
<td>Ratified and implemented, 1994.</td>
<td>Under Chapter 11, the Metalclad Corporation of the United States successfully sued Mexico on toxic waste restrictions. The Methanex Corporation of Canada has sued the United States in a challenge of environmental protections against a carcinogenic gasoline additive.</td>
</tr>
<tr>
<td>Free Trade Area of the Americas (FTAA)</td>
<td>Extends NAFTA to all countries of the Western Hemisphere except Cuba.</td>
<td>Under negotiation.</td>
<td>This trade agreement would open public sector health-care services and institutions to corporate participation.</td>
</tr>
<tr>
<td>General Agreement on Trade in Services (GATS)</td>
<td>May open public sector health care services, national health programs, public hospitals and clinics, professional licensure, water, and sanitation systems to participation by private corporations.</td>
<td>Applies to WTO member nations; commitments by countries currently under negotiation.</td>
<td>Country requests have targeted state and national licensing requirements for professionals and restrictions on corporate involvement in water and sanitation systems.</td>
</tr>
<tr>
<td>Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)</td>
<td>Protects patents, copyrights, trademarks, and industrial designs across national boundaries; limits governments' ability to introduce medication programs (such as antiretroviral medications) and to restrict the availability and reimbursement of medications under publicly funded programs.</td>
<td>Applies to WTO member nations; rules concerning medications for conditions like AIDS under negotiation.</td>
<td>On behalf of pharmaceutical corporations, the United States has challenged attempts by South Africa, Thailand, and Brazil to produce low-cost anti-retroviral medications effective against AIDS.</td>
</tr>
<tr>
<td>Agreement on Technical Barriers to Trade (TBT)</td>
<td>Reduces barriers to trade that derive from technical standards and regulations applying to the safety and quality of products; covers tobacco and alcohol control, toxic substances and waste, pharmaceuticals, biological agents, foodstuffs, and manufactured goods.</td>
<td>Applies to WTO member nations.</td>
<td>In its challenge of France’s ban on asbestos imports, Canada argued that international standards require the “least trade restrictive” regulations; a WTO tribunal approved the challenge, although an appeal tribunal rejected the Canada’s claim after international pressure.</td>
</tr>
<tr>
<td>Agreement on the Application of Sanitary and Phyto-Sanitary Standards (SPS)</td>
<td>Reduces barriers to trade that derive from governments’ regulations and laws designed to protect the health of humans, animals, and plants; covers food safety provisions.</td>
<td>Applies to WTO member nations.</td>
<td>On behalf of the beef and biotechnology industries, the United States successfully challenged the European Union’s ban of beef treated with artificial hormones.</td>
</tr>
</tbody>
</table>

Source: Shaffer et al., 2005.

aRegional trade agreements (apply only to signatory nations).
bWTO trade agreements (apply to all WTO member nations).

reports are intended to attract support from targeted groups of consumers, professionals, non-professional workers, and environmentalists. All US companies, including MNCs, whose securities are publicly traded, as well as investment advisors, are required to file reports for the US Securities and Exchange
Commission; usually such reports are accessible in printed or electronic form. We obtained these reports, as available, for the targeted organizations from 1980 to 2004. In general, the printed reports were readily available from the organizations’ public relations personnel. Many reports also were accessible through the Internet.

For Spanish-language bibliographic materials and interview notes, the first two authors independently prepared translations from Spanish and resolved differences through discussion.

Data analysis and interpretation

For the analysis of these data, as in our previous research, we used established analytic techniques for qualitative research, influenced by Strauss and colleagues (Strauss & Corbin, 1998). In a series of steps, we categorized the bibliographic database, field notes, and transcripts according to stakeholders’ constructions of the social realities linking trade and health. First, “open coding” involved an unrestricted, line-by-line analysis of the field notes, to produce provisional concepts and categories. Later, “axial coding” organized these provisional categories into broader conceptual dimensions of protagonists’ constructions. We tried to clarify variations in these constructions, especially sources of debate and controversy. Software for qualitative data analysis, Atlas.ti (Muhr, 1999), assisted in the process of coding and categorization.

Data analysis from the interviews also relied on the analytic techniques suggested by Mishler (1986). This approach identified specific “voices” in the interview narratives. As in our recent investigations (Stocker et al., 1999; Iriart et al., 2001), we applied narrative analysis to notes and transcripts from the interviews. The analysis clarified the connections between thematic content and the social context of policies linking globalization and health.

Results

Government agencies

In interviews and policy statements, the US and Latin American governments constructed public health and health services in fundamentally different ways. The policy orientations of US government agencies emphasized the importance of public health and health services in fostering US interests worldwide. Rather than viewing health as an end in itself, public statements of such agencies usually promoted health initiatives as a way to advance US interests. For instance, the official global health website of the US Department of Health and Human Services clarified this emphasis on the role of the country’s national interests in promoting health around the world:

The health of Americans is a global concern. The United States must engage health policy globally to protect Americans’ health and to protect America’s vital interests (US Department of Health and Human Services, 2003).

This vision corresponded to the US government’s long-standing policy orientation regarding globalization, as enunciated by Henry Kissinger, which emphasized the country’s dominance among nations:

The basic challenge is that what is called globalization is really another name for the dominant role of the United States (Kissinger, 1999).

On the other hand, US government officials in interviews described the importance of balance between trade and health in policy decisions and recognized contradictions which arise in the promotion of trade. From this viewpoint, government officials responsible for trade negotiations must weigh the advantages for trade versus the disadvantages for health. As the director of negotiations for a major international trade agreement under the Office of the US Trade Representative stated, this task raises challenges:

There is a sense that health policy is as important as trade policy. There is a balance that exists between them, that includes protecting human health and protecting trade, the rights of investors, intellectual property rights; the goal is to find the balance.

The respondent then described this balance in more detail:

Without that balance, the system breaks down, you don’t get investment if you can’t protect it; but if you can’t protect the people’s health, and activities that protect their health, you don’t get their support and then don’t get investment in the system.

According to this construction, global trade generates improved economic conditions, which in turn lead to improved health services. Similarly, trade agreements between governments can achieve prosperity and secondarily can enhance access to care:

I think that one analysis is that removing barriers to trade and investment helps prosperity and improves living standards of people in the countries involved. In turn, as the standard of living rises, so do things like the quality of health care available and health policies put in place by governments and demanded by citizens, etc.
To achieve such changes, government-based trade negotiators should aim toward uniform policies among nations:

We think it’s important for all countries to have the same view, to be looking that it’s important to have a balance between health policy and trade policy.

However, policies that favor global trade also can lead to negative consequences if not prevented by trade agreement negotiators:

If done right, it [globalization] helps the world economy, raises living standards, and removes barriers to development. If done wrong, it can do some pretty serious damage to those elements, and to other things like the environment and public health. If one isn’t careful it can create perverse incentives that in long run aren’t to anyone’s benefit. The trick is to balance them out.

In our interviews with US government officials, we found a range of opinion regarding global trade. Some emphasized that US economic interests should determine policy priorities (as on the global health website). Others (like the trade agreement negotiator) stressed the importance of “balance” between trade and health concerns. All respondents favored market principles as a source of beneficial results in health, because global trade leads to economic prosperity and resulting improvements in health services and well-being.

In contrast, and regardless of their political affiliation or current position, government officials in Mexico expressed pessimism about the impact of global trade on public health and health services. When asked for a definition of economic globalization, the director of health services in one of Mexico’s largest cities responded:

[Globalization is] the imposition of a new model of global accumulation which privileges the financial sector.

About the benefits of international trade agreements, the same respondent commented:

I do not think [there is any]. The information flow does not change.

Regarding negative effects, the respondent answered:

Actors in the free trade area have power over policies. The government is desperate to attract investors... They become private actors in policies... especially the insurers.

Another respondent, who directed a major foundation and served as an advisor to the national Ministry of Health, described negative effects of global trade on health:

There is a possibility that US or foreign corporations could come and invest. What are the corporations’ objectives? Usually they want to increase the production of their capital…. If not guaranteed, you will not see a positive effect for the health system, despite a positive effect for them [the corporations].

As a definition of economic globalization, the dean of a large, public sector health sciences center stated:

[It is] subordination to the policies of the IMF, the World Bank, and the transnationals [corporations]. The US gets a cold; we get pneumonia. [It is] subordination to multinational organizations. The concept of the nation disappears under globalization.

Across the spectrum of Latin American respondents, we found little variation in the concern expressed about adverse effects of global trade. The informants consistently responded that historically Latin American governments have defined health as a right and health care as a public good. They noted that this orientation has changed due to the structural reforms imposed by IFIs. Latin American respondents also perceived that, in practice, US health policies place profit before the needs of the population.

International financial institutions

IFIs have emphasized the importance of private, market mechanisms to achieve efficient and cost-effective policies. As a World Bank official expressed, the main obstacle to the institution’s mission of “a world without poverty” involves governments that remain uncommitted to reform their public sector services. By encouraging economic development and prosperity, in this construction, international trade agreements enhance health outcomes:

The evidence supports a view that these agreements increase people’s real income. It’s not a zero sum game. Creating a larger trading area makes everyone better off materially. There is a link between material improvement (people get richer) and health outcomes like infant mortality. There is also a huge effect also of scientific spillover…. It’s indisputable that the spread of information has been a powerful positive influence.

In this construction, market mechanisms encouraged by trade agreements affect health outcomes through economic development, rather than through specific organizational structures for health services. As opposed to health services, public health demands a strong public sector:

In helping communities meet objectives, the economic framework holds that public goods can’t be provided through markets. Government has to do these things due to externalities…. Traditionally, if
you try to address malaria by wiping out some types of mosquitoes, it’s hard to imagine that the private market would take care of that. It’s hard to sell that activity, as opposed to aspirin, where you can have a market. To eradicate mosquitoes, you must have collective action. You can divide up interventions to determine what is not comprehensively provided by private providers.

The World Bank’s emphasis on privatization thus approaches a limit, since public health problems may require public sector actions unattractive to private providers and investors.

According to the same respondent, the World Bank encourages self-determination in policy making at the local level. By this construction, the World Bank lacks a specific overall policy that applies to public health and health services throughout the world:

It’s a common misperception that the World Bank has views on things, but there are few areas in which the World Bank has official views. There are not many official views on health policy… . Our role is to help communities implement innovations… and evaluate them.

Like the World Bank’s published documents, this respondent and others expressed an official position that the IFIs’ economic policies do not infringe on countries’ autonomy to make their own policy decisions about public health and health services. The respondent expressed a construction that economic analyses work best in a context of freedom:

The World Bank is not ideological institution. We’re interested in results…. The model is to help communities identify objectives; if you want to meet objectives by contracting out to private firms, then let’s do an analysis of the results…. I believe in freedom. In the end, societies have to develop what they want. Economists help with tradeoffs in their deciding what they want.

In this construction, the freedom of the private marketplace leads to more cost-effective health services, while the public sector can assist with public health necessities that the private sector cannot sell. Whether a country accepts a recommendation tied to a World Bank loan, according to this construction, occurs in a process of local determination and freedom of decision making.

**International health organizations**

Since international health organizations recently have begun to coordinate their activities more explicitly with IFIs and trade organizations, these three types of organizations have adopted increasingly similar policies. Respondents in WHO and PAHO, like the official publications of these organizations, favored collaborations that strengthen private-sector, market-oriented policy reforms. Health officials also supported international trade agreements in public health and the reorganization of health services. As a respondent at PAHO noted:

**PAHO was created to facilitate trade in the region…. Right now we are taking positively that countries are involved and discussing trade agreements. But trade agreements may have positive or negative aspects of health.**

In this construction, international health organizations should take an active role in trade negotiations, so the new agreements will protect public health:

For example, 5 years after MERCOSUR [the Common Market of the Southern Cone, or Southern Common Market] was created, after public health people weren’t interested, they approved more than 200 resolutions with little input from health sector. Then we decided to change our approach… participate to expand the health agenda in those agreements, to make sure that health priorities are taken into consideration, to influence agreements to avoid negative implications.

This construction sees no inherent conflict between global trade and public health, as long as international health organizations encourage consideration of health issues during trade negotiations. The same construction manifests itself in WTO’s and WHO’s recent commitment to collaborate in issues of trade (WTO–WHO, 2002; Armada, Muntaner, & Navarro, 2001).

Regarding a perceived loss of national sovereignty in health policies under international trade agreements, an interviewee responsible for trade and health at an international health organization emphasized the benefits of supranational governance:

National governments are transferring some responsibilities to civil society or the private sector…. Some responsibilities are transferred to supranational levels, or are requiring creation of some supranational capacity because they [national governments] can’t be done at the national level…. Sometimes they are creating regulations that are much better than the regulations prevailing in the member countries.

In this construction, supranational governance will exert favorable rather than adverse effects on health:

They [international trade organizations] are telling governments what they should do. Countries are expected to incorporate decisions made at the supranational level into their internal policies…. Most decisions are positive. For instance, they are discussing medicines, cooperation about medicines,
use of excess capacity in production of a given service... they can exchange that capacity at a regional level, for instance, by the recognition of [professional] diplomas, and [harmonized regulations about] ... the importation and exportation of food.... Under subregional arrangements, I don’t see many problems of negative implications.

Trade negotiations among less developed countries, according to the respondent, also give an opportunity to practice and refine their skills for more challenging negotiations with developed countries and MNCs:

Countries in subregional [trade] organizations get experience, expertise, and negotiating capacity, before they engage in a negotiation, for example, with the United States or Canada.... It’s a very inefficient process right now. For example, the case of pharmaceuticals is discussed by MERCOSUR and Andean countries at 7 different venues.... MERCOSUR, PAHO, FTAA, WTO, etc... It’s challenging for less developed countries to be effective in so many instances.

By this construction, a pragmatic approach will prepare the less developed countries to participate more effectively in trade negotiations and agreements.

**Multinational corporations**

In global trade as it pertains to public health and health services, MNCs have emerged as major protagonists. Corporate interests figure in virtually every international trade agreement currently or recently under negotiation (Table 1). Among MNCs, pharmaceutical corporations have played a crucial role in policy decisions linking global trade, public health, and health services. These corporations have influenced several trade agreements, especially the TRIPS agreement which protects patented medications.

Our interviews showed the importance of intellectual property protections in the constructions of corporate strategies among pharmaceutical executives. These executives saw patent protections as essential in facilitating voluntary efforts to deal with the health problems of less developed countries. Unexpectedly, they emphasized that such non-economic goals figured more prominently than anticipated profits in corporate policy decisions. For example, the vice president for international operations of a leading pharmaceutical company stated that protection of intellectual property under the TRIPS agreement proved especially important for scientists in less developed countries:

There are people who can do research, biotechnology, they need legislation to protect their discoveries and innovations. In that context, TRIPS is ... a platform for emerging countries to work as partners in innovation, clinical research, and biotechnology.... People in emerging markets need to receive a just reward for their work—just as we ask here for a just reward for the billions of US dollars that we put at risk each year.

In this construction, intellectual property provisions go beyond assuring profitability for the corporation because they also help foster the work of investigators in countries where career advancement otherwise would prove difficult.

Reflecting another construction of social reality, this respondent expressed a connection between intellectual property protections and corporate responsibility to provide medications for the needy:

The environment must be characterized by strong intellectual property rights and freedom of pricing... these characteristics are not antagonistic to social responsibility to those patients out of work, out of health care protection, who can’t afford to pay for new drugs. We have our own foundations... we do a lot of these activities.

In the interview, the executive provided examples of corporate responsibility facilitated by intellectual property rights:

We don’t operate in isolation but have social responsibility. The best example of a private company working with government is our partnership with South Africa and Sub-Saharan Africa. We bring [patented anti-fungal medication] free of charge to populations that cannot pay. We also help with infrastructure and education of thousands of people, for example in the International Trachoma Initiative. Today, we provide [patented antibiotic] free of charge to people in Morocco, Mali, and Vietnam, even in locations where we don’t have a business at all, or where [business is] unlikely in the future.

Responding to a probe about the potential tax advantages of such contributions, the respondent asserted that such financial considerations do not figure prominently in decision making:

There may be some tax benefits particularly in this country. But I don’t think this is an issue. It takes a tremendous decision to fly to South Africa and say to the government: you have a large population dying from fungal infections. We are going to bring our drug, [patented anti-fungal medication], free of charge, [for] people who can’t pay 10 dollars or 10 cents.... You won’t believe the time and efforts that I and the chairman have spent on this issue... in the World Economic Forum, the UN, advocating for other companies to do the same with the poor
African who cannot afford to pay.... We have our core mission... we want to be seen as the most valued company in the world. We have more assets in emerging markets than any other company.

Re-emphasizing the construction of non-economic motivation in corporate responsibility, the executive referred to the impact of ideas in decision making. In his case, he argued, such ideas derived in large part from personal experiences of poverty. When asked about resistance to globalization and alternative projects linking global trade and health policies, he stated:

It's really a shame.... I hear comments that globalization is a cause of poverty in country A or country B. I'm surprised because these countries are where globalization hasn't been. I manage the African countries. I came from a poor family in [a country in northern Africa]. I lost my father at the age of 9; I had to work early to take care of my family. Africa needs democracy. No serious person can incriminate globalization as a source of the ongoing unfortunate economic difficulties in Africa.

In this construction, ideas about freedom and social justice comprise stronger motivations than concerns about profitability in corporate decision making. Intellectual property rights then become part of a broader construction of corporate profitability balanced by corporate responsibility.

Advocacy groups

Advocacy groups voiced constructions of reality that differed markedly from most of those considered so far. Spokespersons for these groups emphasized adverse effects of global trade on public health and health services. For instance, one respondent explained that the TRIPS agreement adversely affected the availability of urgently needed medications, especially for AIDS and other endemic infections in Africa:

Intellectual property agreements are horrible. But there is so much activism around the world to curtail the TRIPS agreement and then get that codified. Then there would be a way that trade agreements could do some good for public health, for a change. Pharmaceutical companies don’t see it that way at all and will fight tooth and nail.

In this construction, which respondents from several other advocacy groups echoed, the motivation for intellectual property protection in medication patents derived from economic interests rather than an effort to foster scientific productivity or humanitarian commitment.

Spokespersons for advocacy groups also expressed a construction of contradictions between international trade agreements and free trade as envisioned in economic theory. One respondent argued that trade agreements often restrict free trade:

Free trade agreements have nothing to do with free trade as defined in the economic literature. They are actually complex, detailed agreements about managed trade: which countries can sell which products and services to whom and when. The global economy is being intricately managed and regulated. The question is: who is doing the managing and in whose interest.

This respondent referred to the history of such contradictions:

Those who articulate the free trade paradigm have always been disingenuous. Even when British economists like Adam Smith and David Ricardo spewed free trade rhetoric, it was disingenuous, since all countries that successfully had developed industrial capacity had used trade restrictions and state subsidies. This has been a major role of the state in industrialized countries. The rhetoric of free trade principles had little to do with how countries had industrialized.

Another respondent, who directed the global trade division of a major consumer rights organization, agreed with this construction and argued that trade agreements intrude into arenas far removed from trade, while maintaining the symbolism of free trade:

They’re not free trade .... If free trade, [the agreements] would be three pages long, with few restrictions.... Instead, they have more than 900 pages of rules under agreements, and even longer laws... By using the leading edge of trade, they’ve introduced many other policies. They use international negotiations as a vehicle to change domestic health, pension, and labor policies. Some are anti-competitive, for example, TRIPS.... We want WTO to shrink or to sink... for example, cut back to proper scope... but its role should not be subjectively to set policy decisions about how much pesticide residues on vegetables worldwide, or whether a country decides to set up national health program, or whether a country provides medications.

In this construction, trade rules have extended corporate dominance inappropriately into many new arenas, including public health and health services:

The current economic globalization is simply the imposition worldwide of a comprehensive set of policies, which go beyond economics to include health, human rights, labor, environment, consumer safety.... Decisions are being shifted up and away; for example, decisions affecting a local water system
are shifted to the state, then federal level, then WTO, where absolutely no accountability or access [exists] for individual citizens of the countries affected. If someone finds that they can’t get medicines for granny, it’s not likely that she will protest at WTO’s headquarters on the shores of Lake Geneva.

This respondent also presented a construction of resistance to globalization, as well as alternative projects. These efforts included struggles to protect access to health services and medications:

Probably the most powerful fight-backs are the incredible efforts in the global south to reverse health care privatization. Brazil’s standing up to the US that we are going to produce and distribute AIDS drugs. The US took Brazil to WTO. Brazil fought back in WTO. They also launched a PR [public relations] campaign across the world—the US wants to kill people in Brazil by depriving drugs. In El Salvador, they reversed the privatization of health care... they won. What’s happening as policies kill people around the world, when day to day life is not survivable, people become ungovernable.

Because of such resistance, this respondent and several others expressed optimism that organizing efforts could reverse some of the adverse effects of global trade on public health and health services.

Conclusion

Our multi-method study of global trade, public health, and health services revealed wide diversity in stakeholders’ constructions of social reality. Although policy changes linking trade and health often occur silently—with little attention by legislators, the public media, professional associations, or other organizations of civil society—the informants, published reports, and unpublished documents manifested intense and divergent constructions:

- The constructions of global health policies by US government agencies, which focused on US national interests, differed markedly from those of other governments, particularly in Latin America, which emphasized the right to health.
- As international financial organizations and trade organizations assumed a growing role in public health and health services, they presented a construction that favored privatization of health services, as well as a limited role for public sector activities that focused mainly on unprofitable but necessary public health functions. Respondents speaking for these organizations acknowledged a “balance” between trade and health and saw their jobs as essential in regulating this balance. Trade agreements favored by international financial and trade organizations supported the entry of MNCs into international health care markets.
- Executives of MNCs constructed their motivations in broad humanitarian terms of service to humanity, rather than financial interests based on profitability. They emphasized the importance of intellectual property rights for fostering scientists’ work in less developed countries.
- Respondents for advocacy organizations constructed a reality of unfavorable effects on public health and health services imposed by the policies of trade organizations, IFIs, and MNCs, especially fees that reduced access to services and intellectual property provisions that restricted access to essential medications. Advocacy groups emphasized that “free” trade agreements invoked a restrictive, corporate approach to regulating trade, which extended inappropriately into many new areas of public health and health services.

Social constructions of the relationships among global trade, public health, and health services reflect broad ideologies concerning the impacts of market processes. Although the term conveys varying definitions and theoretical frameworks, ideology generally refers to the distinctive ideas of a social group that help explain social reality and that motivate action (Waitzkin, 1991, 2000; Waitzkin, Britt, & Williams, 1994). Constructions of economic and political processes—such as public welfare systems, criminal justice systems, the organizations that provide mental health services, etc.—often contain ideological components (Edelman, 1974, 1985, 1988, 2001; Berger & Luckmann, 1966; cf. Gergen & Gergen, 2003). That is, in discourses about social problems and how to solve them, organizational stakeholders tend to express visions of empirical reality that define both problems and solutions in terms of ideas consistent with organizations’ interests in survival and growth (Edelman, 1985).

In the documents and discourses produced by stakeholders in our study, quite different constructions emerged, concerning the same empirical conditions. These constructions reflected the ideologies of two distinct groups, which corresponded to what Berger and Luckmann have termed official experts and intellectual experts. Such experts used their ideas to support the interests of the particular social groups which they represented or for which they spoke (Berger & Luckmann, 1966).

In the United States, our respondents working for government agencies, IFIs, trade organizations, and MNCs took on a role of official experts, and their constructions of trade and health manifested features of a “creed”—a set of beliefs concerning the role of
markets in advancing human purposes and meeting human needs. While emphasizing humanitarian benefits of market processes, these constructions also provided a rationale for corporate interests grounded in globalized investment and profit-making opportunities. To a surprising extent, interviewees and official documents of international health organizations like WHO and PAHO also enunciated a faith in market processes and trade agreements to advance the cause of public health (Drager & Vieira, 2002; WHO–WTO, 2002).

Among our respondents in government agencies, IFIs, trade organizations, MNCs, and international health organizations, and in written presentations of organizational policies, we found wide agreement with the position that trade organizations, trade agreements, and intellectual property will likely improve health conditions worldwide. In this construction, official experts regulate trade to enhance patent guarantees through intellectual property rules and to balance the goals of trade and health. Except in Mexico, as shown in our interviews, these respondents manifested optimism that economic globalization will foster public health and access to health services worldwide (cf. Hunter & Yates, 2002). They continued to express an ethical purpose in fostering unfettered market activities en route to human betterment. In this sense, constructions of reality concerning trade and health resembled earlier constructions that conveyed economic competition as a religious value—for instance, in the “Protestant ethic and the spirit of capitalism”; the divine “invisible hand” which reconciles in the marketplace the individual interests of buyers and sellers for the overall benefit of society as a whole; the “American business creed”; and the quasi-spiritual beliefs that motivate post-modern “men and women of the corporation” (Weber, 2001; Smith, 1976; Sutton, 1956; Kanter, 1994; Lebowitz, 2004; cf. Berger, 2002; Marx, 1998b).

The creed linking trade and health also manifested “economism,” a belief system based in “confidence of the markets.” With this belief system, as Bourdieu (1998, 1999, 2003) has argued, policy makers make decisions based on technocratic assumptions that market processes achieve the broadest good across social classes in both economically developed and less developed countries. From this view, official experts in MNCs, IFIs, and international health organizations call upon political leaders to take their advice, rather than relying on democratic, consensus-building processes to evaluate policy decisions (Bourdieu, 1998).

Along the way, a new “common sense” emerges. Official experts construct this common sense, according to several fundamental principles: the causes of the health care crisis are financial; administrative rationality is indispensable to solving the crisis; financing and delivery must be separated to increase efficiency; demand rather than supply should be subsidized; private administration is more efficient and less corrupt than public administration; the market is the best regulator of quality and costs; and deregulation of social security allows the user freedom of choice (Iriart et al., 2001). Our respondents from government agencies, IFIs, trade organizations, international health organizations, and MNCs expressed attitudes consistent with this version of common sense. Likewise, the policies and actions of their organizations generally reflected these principles. In most instances, documents and respondents conveyed these principles as given truths, rather than as assumptions that deserved empirical substantiation.

Intellectual experts in this study represented advocacy organizations, whose criticisms of global trade challenged the official experts’ constructions of reality. While official experts generally provided a rationale for corporate interests on a global scale, the interests fostered by intellectual experts’ constructions (from the Berger–Luckmann perspective) remained less obvious. Aaronson argues that critics of trade agreements, regardless of political affiliation, “have found common ground in their belief that capitalism should serve the nation and not make the nation subservient to MNCs” (2001,p.4). Although respondents for advocacy organizations clearly wished to strengthen their organizations, their constructions of reality generally did not aim to enhance organizational interests as a main goal. Further, respondents in advocacy organizations consistently reported that they earned relatively low incomes and did not seek to gain personal power, either within or outside their organizations. Instead, their constructions usually highlighted relationships of political and economic power that worsen conditions of work, the environment, nutrition, financial security, and access to services and medications for poor people, minorities, the disabled, the elderly, and other disadvantaged groups. As an alternative vision, respondents speaking for advocacy organizations constructed a struggle that served the interests of groups that lacked economic resources and political power. These respondents manifested this orientation when they referred, for instance, to the adverse effects of trade agreements on the availability of needed medications and on the ability of countries to establish national health programs.

In this way, conflicting constructions about trade and health emerged, based on differing interpretations of the empirical evidence on trade and health. In the presence of rival theories, in which “experts may develop vested interests,” argumentation of such theories “does not carry the inherent conviction of pragmatic success. What is convincing to one man may not be to another” (Berger & Luckmann, 1966, p. 119). Although critics of globalization represent an important movement in the United States and many other countries, policy makers often ignore or discount their alternative constructions of reality, in favor of official experts’ constructions.
A growing network of professionals and advocates has drawn attention to these linkages (Kim et al., 2000; Fort, Mercer, & Gish, 2004; Shaffer et al., 2005). Those concerned with health and security worldwide cannot afford to ignore the profound changes generated by global trade. Recognizing and demystifying some constructions of social reality put forward by the key stakeholders in trade and health may become a first step.

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Further reading


