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# 经济、社会和文化权利

## 人人享有能达到的最高标准的身心健康的权利

特别报告员保罗·亨特的报告

增 编

## 对世界贸易组织的访问 * **

* 本内容提要以所有正式语文分发。报告本身作为内容提要的附件，只以原文分发。

** 根据大会第 53/208 号决议 B 部分第 8 段说明如下，本报告迟交是为了列入最新资料。

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# 内容提要

贸易通过诸多途径影响健康权。各国必须确保其选择的贸易规则和政策符合它们在健康权方面承担的法律义务。这引出了一些复杂而有争议的问题。

人人享有能达到的最高标准的身心健康权问题特别报告员考虑到其任务规定，认为他必须努力就这些问题作出适度而有建设性的贡献，以便协助各国和其他行为者。因此，特别报告员在其初步报告中表明有意结合健康权问题来审查贸易规则和政策。正是在这种情况下，并受到已故人权事务高级专员的鼓励，他对世界贸易组织(世贸组织)进行了一次访问。

这份报告试图以通俗易懂的方式介绍一些贸易与健康权交织在一起的技术问题。导言表明特别报告员所采取的方法的一些基本特征，如政策一致性原则。此外，导言还将说明特别报告员的主要焦点是世贸组织成员国，而非世贸组织本身。

报告第一部分结合贸易情况概述健康权的渊源和范围。第二部分介绍一组选定的与健康权有关的具体贸易协定和问题：知识产权(《与贸易有关的知识产权协定》(《涉贸知识产权协定》)和受到忽视的疾病)、服务贸易和《服务贸易总协定》(《服贸总协定》)、影响评估、性别与贸易、技术援助、贸易政策审查机制(贸审机制)，和加入国。第三部分为一系列行为者提供建议。

报告中讨论的协定和问题是特别报告员广泛磋商过程中最常出现的。不幸的是，由于篇幅有限，特别报告员不能探讨所有的贸易协定和问题。特别报告员希望其报告能有助于在这个广泛、复杂而重要的调查领域作出其它贡献。

**Annex**

# REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH, PAUL HUNT, ON HIS MISSION TO THE WORLD TRADE ORGANIZATION

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## Introduction

1. This addendum is the report of the mission of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his mission to the World Trade Organization (WTO) from 16 to 23 July 2003 and 27 to 28 August 2003.

2. To commence preparations for the mission, the late High Commissioner for Human Rights, Sergio de Mello, wrote to the Director-General of WTO, Dr. Supachai Panitchpakdi, on 27 March 2003 proposing a visit to the WTO secretariat by the Special Rapporteur. The letter explained that one of the objectives of the proposed visit was to contribute constructively to the debate about the right to health and international trade. On 13 May 2003, the Director-General of WTO confirmed with the High Commissioner that the WTO secretariat had organized a series of meetings for the Special Rapporteur with directors of various divisions in the organization.

3. In recognition of the fact that WTO is driven principally by its member States, the Office of the United Nations High Commissioner for Human Rights (OHCHR) sent a note verbale to all WTO member and observer States inviting them to an informal discussion on 17 July 2003 on the right to health and trade, led by the Special Rapporteur. OHCHR also sent the note verbale to the regional coordinators of the Bureau of the Commission on Human Rights, to inform permanent missions to the United Nations Office at Geneva of the informal discussion and to invite them to attend. The note verbale also noted the willingness of the Special Rapporteur to meet bilaterally with interested WTO member and observer States, a number of whom responded by inviting the Special Rapporteur to meet with them. OHCHR also sent an invitation to non-governmental organizations (NGOs) inviting them to an informal briefing on 23 July 2003.

4. As a result, the Special Rapporteur held meetings with (a) WTO secretariat: representatives of the Intellectual Property Division, the Trade in Services Division, the Legal Affairs Division, the Trade and Finance Division, the Trade Policies Review Division and the Institute for Training and Technical Cooperation; and (b) the Chairpersons of three councils: H.E. Ambassador Ousmane Camara of Senegal (Chairperson of the Council for Trade in Services), H.E. Mr. Vanu Gopala Menon of Singapore (TRIPS Council) and H.E. Mr. Carlos Pérez de Castillo of Uruguay (General Council). He held an informal discussion with WTO members and observers on 17 July which was attended by some 35 delegates, and bilateral meetings with WTO members. Brazil, China, the European Commission, Gabon, India, Mexico, Nigeria, Oman and Switzerland. He also met with representatives of the World Health Organization (WHO), the World Intellectual Property Organization (WIPO) and the Advisory Centre on WTO Law, the Acting High Commissioner for Human Rights, Betrand Ramcharan, and NGOs.

5. Without exception, these multiple meetings were constructive, informative and helpful. So far as the Special Rapporteur is aware, the discussion of 17 July was one of the first occasions that WTO members and observers - for the most part trade specialists - had engaged in a discussion on the right to health. The Special Rapporteur would like to record his deep appreciation to all those who generously made available their time, knowledge and expertise.

**Selected WTO Agreements and issues**

6. Several WTO Agreements, and many trade issues, bear upon the right to health. While they raise complex and technical matters, this report has to be confined to 10,700 words. Rather than attempting to address all Agreements and trade issues in this limited space, the report adopts a selective approach: it focuses on those Agreements and issues that emerged most clearly during the Special Rapporteur's consultations. He wishes to emphasize that just because the report does not address particular Agreements or issues, this does not mean that they are unimportant in the context of the right to health. He hopes that the omitted Agreements and issues - particularly the Agreement on Technical Barriers to Trade, the Agreement on Sanitary and Phytosanitary Measures and WTO dispute settlement - will be subject, in due course, to a detailed analysis through the prism of the right to health.[1]

**A primary focus on States, rather than WTO**

7. For two reasons, the primary focus of this report is on the position of States in relation to selected trade issues and the right to health, rather than the responsibilities under international human rights law of WTO and its secretariat. First, WTO is principally driven by its member States and, second, international human rights law primarily places obligations on States. Thus, given constraints of space, it would appear most fruitful to focus on the relationship between States, the right to health and trade. The Special Rapporteur hopes that other opportunities will arise for consideration of the legal argument that WTO, and its secretariat, themselves have international human rights responsibilities.

**The Millennium Declaration and Millennium Development Goals**

8. All States Members of the United Nations - which includes all members of WTO - have agreed to the framework for development set out in the Millennium Declaration and Millennium Development Goals. Today, the overarching national and international policy objective is the reduction of poverty (goal 1). At least four of the eight goals are health related. Elements of a fifth - developing a global partnership for development (goal 8) - also bear closely upon the right to health. Not only all States, but also all members of the "United Nations family", including the Bretton Woods institutions, are firmly committed to the realization of the Goals. For his part, the Director-General of WTO has also affirmed the vital importance of the Goals. Thus, the realization of all the Millennium Development Goals, including those that are health related, should be a central objective of all relevant national and international trade rules and policies.

**Policy coherence**

9. The Special Rapporteur's work is guided by the fundamental principle that national and international human rights law, including the right to health, should be consistently and coherently applied across all relevant national and international policy-making processes, including those relating to trade. This highlights one of the greatest challenges confronting international human rights law: the problem of "disconnected" Government. Practice shows that one part of Government does not necessarily grasp what another part of the same Government has agreed to do. Increasingly, States recognize this is a problem and some of them are trying to address it by "mainstreaming" human rights.[2]

10. In this context, the Special Rapporteur notes the endeavours of WTO, the World Bank and the International Monetary Fund (IMF) to ensure greater coherence between trade, development and finance. This powerful trend has far-reaching implications that are beyond this report. However, the Special Rapporteur wishes to emphasize that enhanced coherence should not be confined to policies that only deal with trade, development and economics. What is needed is a coherent approach to the application of a State's various national and international obligations, including those relating to trade, development, economics and human rights.

**The relationship between trade liberalization and international human rights law**

11. International human right law takes a position neither for nor against any particular trade rule or policy, subject to two conditions:[3] first, the rule or policy in question must, in practice, actually enhance enjoyment of human rights, including for the disadvantaged and marginal; second, the process by which the rule or policy is formulated, implemented and monitored must be consistent with all human rights and democratic principles. Thus, if reliable evidence confirms that a particular trade policy enhances enjoyment of the right to health, including for those living in poverty and other disadvantaged groups, and that policy is delivered in a way that is consistent with all human rights and democratic principles, then it is in conformity with international human rights law. However, if reliable evidence confirms that a particular trade policy has a negative impact on the enjoyment of the right to health of those living in poverty or other disadvantaged groups, then the State has an obligation under international human rights law to revise the relevant policy. This does not necessarily mean that the particular policy has to be altogether abandoned - it might mean that it has to be revised in such a way that it begins to have a positive impact on the enjoyment of the right to health of those living in poverty and other disadvantaged groups.

12. This position has a number of important implications that are examined further in this report. Among the most important is that international human rights law requires reliable evidence that a chosen rule or policy is delivering positive right to health outcomes, including for the disadvantaged. If a policy is at the planning stage, international human rights require that reliable assessments be undertaken to anticipate the likely impact of the policy on the enjoyment of the right to health of those living in poverty and other disadvantaged groups. Thus, international human rights law promotes rational and rigorous national and international policy-making that is based upon reliable data. The next section of this report outlines some of the other characteristics of a right to health approach to trade, such as participation and accountability.

## I. THE RIGHT TO HEALTH: AN OVERVIEW IN THE CONTEXT OF TRADE

13. The numerous consultations that contributed to the Special Rapporteur's mission tended to confirm that the right to health is not well understood among some of those working on trade issues, just as trade is not well understood among some of those working on human rights. It is for this reason that section I outlines the sources and scope of the right to health. The Special Rapporteur hopes that this section will not only enhance understanding of the right to health, but also facilitate the further application of that right to all WTO Agreements and trade issues, including those that it has not been possible to address in this report.

## A. Sources of the right to health: international, regional and national

14. In his preliminary report to the Commission on Human Rights, the Special Rapporteur outlines the international, regional and domestic sources of the right to health. He also identifies the numerous recent resolutions of the Commission that affirm, or bear closely upon, the right to health, as well as international conference outcomes, such as the Millennium Declaration, that relate to the right to health.[4]

15. Although the Special Rapporteur will not repeat this survey here, he wishes to emphasize that the international right to health is a firmly established feature of binding international law. Adopted in 1946, the Constitution of WHO recognizes the fundamental human right to health. Two years later, the Universal Declaration of Human Rights laid the foundations for the international legal framework for the right to health. Since then, the right to health has been codified in numerous legally binding international and regional human rights treaties. The most extensive treaty elaboration of the right to health is in the Convention on the Rights of the Child, which has been ratified by all States, bar two. Further, these binding treaties are beginning to generate case law and other jurisprudence that shed light on the content of the right to health, and from which the Special Rapporteur draws in his preliminary report. The right to health is also enshrined in numerous national constitutions: over 100 constitutional provisions include the right to health, the right to health care, or health-related rights such as the right to a healthy environment. Moreover, in some jurisdictions constitutional provisions on the right to health have generated significant jurisprudence, such as the recent decision of the Constitutional Court of South Africa in *Minister for Health v. Treatment Action Campaign.*[5]

16. These human rights cases - and numerous other laws and decisions at the international, regional and national levels - confirm the justiciability of the right to health. Of course, several cases decided by the dispute settlement regime of WTO have considered health-related issues.[6] A crucial legal challenge is to maintain consistency between these two related and developing bodies of jurisprudence.[7]

## B. The scope of the right to health

17. The international right to health has normative depth and can make a constructive contribution to trade rules and policies. Here the Special Rapporteur confines himself to a brief sketch of the content of the right to health.[8]

18. *Health care and the underlying determinants of health; freedoms and entitlements*. The right to health is an inclusive right, extending not only to timely and appropriate health care, including access to essential medicines, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation.

19. The right to health contains both freedoms and entitlements. Freedoms include the right to be free from discrimination and non-consensual medical treatment. Entitlements include the right to a system of health protection (i.e. health care and the underlying determinants of health) that provides equality of opportunity for people to enjoy the highest attainable standard of health. The right to health is a broad concept that can be broken down into more specific entitlements, such as the right to essential medicines.

20. In short, the right to health can be understood as a right to the enjoyment of a variety of facilities, goods and services necessary for the realization of the highest attainable standard of health. Increasingly, health facilities, goods and services are subject to trade rules and policies. Thus, it is of growing importance to examine the numerous areas where trade and the right to health converge.

21. *Progressive realization; immediate obligations*. The full realization of the right to health is subject to the availability of resources. Since resource constraints cannot be eliminated overnight, international law expressly allows for the progressive realization of the right to health. However, progressive realization is subject to various conditions, otherwise pursuit of the right to health might be constantly postponed, emptying the right of any meaning. For example, progressive realization means that States have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the right to health.

22. The right to health imposes various other obligations of immediate effect, notwithstanding resource constraints and progressive realization. These immediate obligations include the guarantees of non-discrimination and equal treatment, as well as the obligation to take deliberate, concrete and targeted steps towards the full realization of the right to health, such as the preparation of a national public health strategy and plan of action. The right to health also includes obligations to ensure the satisfaction of, at the very least, minimum essential levels of health care and the underlying determinants of health.

23. The progressive realization of the right to health, and trade rules and policies, relate to each other in several ways. First, trade has the potential to increase resources and thus to contribute to the progressive realization of the right to health. Second, if trade generates more resources, they have to be allocated in such a way that they do, in practice, contribute to the progressive realization of the right to health for all; a national health strategy and plan of action can help to ensure that the necessary allocations occur. Third, the effect of trade on the progressive realization of the right to health depends upon the trade rules chosen: different forms, pacing and sequencing of trade liberalization have different effects on progressive realization. The right to health requires that the form, pacing and sequencing of trade liberalization be conducive to the progressive realization of the right to health. Fourth, it is axiomatic that a State establishes effective and transparent mechanisms to monitor whether or not the selected trade (and other) policies are progressively realizing the right to health.

24. In summary, progressive realization of the right to health, and the immediate obligations to which it is subject, place reasonable conditions on the trade rules and policies that may be chosen. These conditions are designed to ensure that the selected trade rules and policies actually deliver positive right to health outcomes for all.

25. *Non-discrimination and equal treatment.* Non-discrimination and equal treatment are among the most critical components of the right to health. International human rights law proscribes any discrimination in access to health care, and the underlying determinants of health, on the internationally prohibited grounds, such as sex, race and social origin, that has the intention or effect of impairing the equal enjoyment of the right to health. The Special Rapporteur highlights the word “effect”: even an unintended discriminatory effect may be in breach of international human rights law. In the present context this is very important, because trade rules and policies can unintentionally have different impacts on different groups, including

men and women, and these impacts can extend to differential access to health and health-related services. The right to health requires that the differential impact of trade rules and policies be monitored and, where necessary, appropriate policy adjustments made.

26. The principle of non-discrimination is also an important component of international trade law. While there are some similarities between the trade and human rights principles of non-discrimination, they are also different in scope and application. The human rights principle has been intimated above: it reflects a particular preoccupation with those who are disadvantaged, vulnerable and living in poverty. On the other hand, the trade principle of non-discrimination is primarily designed to reduce trade protectionism and to ensure that a Government's policies to regulate international commercial transactions apply regardless of the origins of the goods, services or service supplier.[9]

27. *Participation.* The human right to participate in the conduct of public affairs is inextricably linked to fundamental democratic principles. Fulfilment of this right includes more than free and fair elections, and extends to the active and informed participation of individuals and communities in decision-making that affects them. Thus, the right to participate should inform the formulation of both trade and right to health policies.

28. *International assistance and cooperation*. States have an obligation to take steps, individually and through international assistance and cooperation, towards the full realization of the right to health. Importantly, international assistance and cooperation should not be understood as encompassing only financial and technical assistance: it also includes a responsibility to work actively towards equitable multilateral trading, investment and financial systems that are conducive to the elimination of poverty and the realization of the right to health. For example, States should respect the enjoyment of the right to health in other jurisdictions, and ensure that no international trade agreement or policy adversely impacts upon the right to health in those other countries. They should also ensure that their representatives to international organizations, including WTO, take due account of the right to health, as well as the obligation of international assistance and cooperation, in all policy-making matters.

29. The human rights concept of international assistance and cooperation reinforces WTO members' commitment to technical assistance and capacity-building which, especially since Doha, is a crucial feature of the responsibilities of WHO.

30. *Responsibilities of all actors.* While States have primary responsibility for the realization of international human rights, all actors in society - individuals, local communities, intergovernmental and non-governmental organizations, health professionals, private businesses and so on - have responsibilities regarding the realization of the right to health.

31. *Accountability*. Like any other human right, the right to health is almost meaningless if unaccompanied by mechanisms of accountability. From the right to health springs duties - and in relation to these duties there must be transparent, effective and accessible mechanisms of accountability. Accountability mechanisms come in many forms, perhaps the most well-known being judicial (e.g. judicial review of executive acts) and political (e.g. parliamentary processes). But there are other forms of accountability, such as quasi-judicial devices (e.g. health ombuds) and administrative arrangements (e.g. the preparation and publication of right to health impact assessments). The form and mix of right to health accountability mechanisms will vary from one

State to another - but together they have to provide transparent, effective and accessible accountability. Given that non-State actors have responsibilities in relation to the realization of the right to health, accountability mechanisms are needed in relation to both States and other actors whose actions bear upon enjoyment of the right to health. Accountability depends upon sound monitoring. The primary purpose of monitoring and accountability mechanisms is to ensure that timely adjustments are made to national and international trade (and other) policies when reliable evidence shows that they are not delivering outcomes consistent with the international right to health.

32. It is because a right to health approach to trade requires transparent, effective and accessible mechanisms of monitoring and accountability that this report considers impact assessments and the Trade Policy Review Mechanism (TPRM). Of course, these monitoring and accountability mechanisms are not sufficient. Nonetheless, they may constitute two modest but practical ways to enhance monitoring and accountability in relation to trade and the right to health.

## C. The right to health: two analytical frameworks

33. In recent years, the human rights community has developed analytical frameworks or tools that are designed to deepen our understanding of human rights, including the right to health. In the context of trade, this section outlines two of these complementary frameworks, the first being especially relevant to policy analysis.

### Availability, accessibility and good quality

34. The right to health requires that health facilities, goods and services shall be *available*, *accessible* and of *good quality*.[10] By way of illustration, in the following paragraphs, this framework is briefly applied to an issue that is both an element of the right to health and a feature of contemporary trade: access to essential medicines.

35. *Available*: the State has to do all it reasonably can to make an essential medicine available in its jurisdiction e.g. by using, where appropriate, the TRIPS flexibilities, such as compulsory licences and parallel imports.

36. *Accessible*: however, making the essential medicine available in the jurisdiction is not enough. The medicine might be available in a State, but only in the urban centres, not the rural areas; or only to some ethnic groups, not others; or only to the rich, not those living in poverty; or only to people without disabilities; and so on. Thus, the State has to do all it reasonably can to ensure that the essential drug is not only available in the jurisdiction, but accessible to all.

37. Access has at least four dimensions:

(a) *Non-discrimination.* The essential medicine must be accessible to all, in law and fact, without discrimination on any of the internationally prohibited grounds, such as sex, race and social origin. For example, delivery mechanisms will be needed to reach disadvantaged groups, such as women, minorities, indigenous peoples, slum-dwellers and labour migrants;

(b) *Physical access.* The essential medicine must be accessible in all parts of the country, including rural areas. For example, mobile clinics might be needed;

(c) *Economic accessibility*. Whether publicly or privately provided, the essential medicine must be affordable to all, not just the well-off. Clearly, the affordability of essential medicines raises crucial issues, such as drug pricing, compulsory licences, parallel importing, and the reduction of import duties;

(d) *Information*. Accurate public health-related information must be accessible to all, including information regarding the essential medicine.

38. *Quality*: making the essential medicine available and accessible is not enough. It could be available and accessible in a jurisdiction, but of poor quality e.g. counterfeit, contaminated or sub-standard. Sometimes drugs, rejected in the North because they have passed their expiry date, are sold in the South. Thus, States need to have in place a basic system for monitoring essential drug quality.

**Respect, protect and fulfil**

39. While the analytical framework outlined above is especially relevant to policy analysis, the framework of respect, protect and fulfil is more suited to legal analysis.

40. The duty *to respect* requires States to refrain from interfering, directly or indirectly, with the enjoyment of the right to health. Thus, a State should not market unsafe drugs or unlawfully pollute the environment from State-owned facilities. The duty *to protect* requires States to take measures that prevent third parties from interfering with the right to health. Thus, a State is obliged to regulate health service provision with a view to eliminating the marketing of unsafe drugs and reducing professional malpractice. It is also obliged to ensure that a privatized health sector enhances the realization of the right to health of all, including those living in poverty. The obligation *to fulfil* requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health. This includes the residual obligation to provide the various elements of the right, such as access to an essential medicine, when an individual or group, for reasons beyond its control, is unable to enjoy that element itself by the means at its disposal.

## II. A SELECTION OF TRADE ISSUES AND THE RIGHT TO HEALTH

### A. Intellectual property and access to medicines

#### 1. The TRIPS Agreement

41. The Agreement on Trade-Related Aspects of Intellectual Property Rights (the TRIPS Agreement) is the most comprehensive multilateral agreement that sets detailed minimum standards for the protection and enforcement of intellectual property rights. The forms of intellectual property protection covered by the TRIPS Agreement most relevant to the enjoyment of the right to health include patent protection (over new medical processes and products such as pharmaceuticals), trademarks (covering signs distinguishing medical goods and services as coming from a particular trader), and the protection of undisclosed data (in particular test data). For example, patent protection of a pharmaceutical allows the intellectual property right holder to exclude competitors from certain acts, including reproducing and selling the drug for a minimum period of 20 years. This period of exclusion theoretically allows the right holder to

recoup some of the costs involved in medical research. Apart from establishing minimum standards for various forms of intellectual property protection, the Agreement also allows WTO member States to adopt measures to protect public health and nutrition, and to protect against the abuse of intellectual property rights in certain cases. The Agreement makes disputes between WTO members concerning respect for the minimum standards subject to the WTO dispute settlement procedures.

42. Intellectual property protection can affect the enjoyment of the right to health, and related human rights, in a number of ways. Importantly, intellectual property protection can affect medical research and this can bear upon access to medicines. For example, patent protection can promote medical research by helping the pharmaceutical industry shoulder the costs of testing, developing and approving drugs. However, the commercial motivation of intellectual property rights encourages research, first and foremost, towards "profitable" diseases, while diseases that predominantly affect people in poor countries - such as river blindness - remain under-researched. This report returns to this issue under "Neglected diseases" below. Further, intellectual property rights may affect the use of traditional medicines such as those of indigenous peoples. While existing intellectual property protection can promote the health innovations of indigenous and local communities, the particular nature of this knowledge and the knowledge holders might require significant amendment to be made to intellectual legislation for protection to be comprehensive. Further, some traditional medicines have been appropriated, adapted and patented with little or no compensation to the original knowledge holders and without their prior consent, which raises questions for both the right to health and cultural rights.

43. The exclusion of competitors as a result of the grant of a patent can also be used by patent holders as a tool to increase the price of pharmaceuticals. High prices can exclude some sections of the population, particularly poor people, from accessing medicines. Given that the right to health includes an obligation on States to provide affordable essential medicines according to the WHO essential drugs list, intellectual property protection can lead to negative effects on the enjoyment of the right to health. In other words, in some cases intellectual property protection can reduce the economic accessibility of essential medicines. The TRIPS Agreement includes some flexibility in such circumstances by permitting WTO members to authorize third parties to work a patent (i.e. manufacture and sell pharmaceuticals at a lower price) without the authorization of the patent holder, subject to certain limitations including payment of a reasonable fee. Nonetheless, such flexibilities are, in reality, only available to those WTO members that have a domestic pharmaceutical manufacturing capacity. Article 31 (f) of the TRIPS Agreement allows unauthorized working of the patent where sale is dominant locally. Thus, poorer countries without adequate manufacturing capacity might not be able to benefit from these flexibilities. The Special Rapporteur welcomes the Decision on Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health (August 2003) allowing countries producing generic copies of patented drugs under compulsory licence to export drugs to countries with no or little drug manufacturing capacity. The Special Rapporteur notes that the protracted negotiations that led to this Decision should have been informed by the human rights responsibility of rich States to engage in international assistance and cooperation in relation to the right to health. The Special Rapporteur underlines that the effectiveness of the Decision will depend on the extent to which it actually does lead to increased access to medicines for the poor.

### 2. Neglected diseases

44. In his preliminary report, the Special Rapporteur stressed that neglected diseases and very neglected diseases are human rights issues. In particular, very neglected diseases - those diseases overwhelmingly or exclusively occurring in developing countries, such as river blindness and sleeping sickness - receive little research and development, and very little commercially-based research and development in wealthy countries. The possibility of recouping research and development costs by excluding competition from the market through the use of intellectual property rights assumes that there is a market for new medicines in the first place. The fact that very neglected diseases are suffered overwhelmingly by poor people in poor countries underlines that there is no or little market potential for medicines fighting these diseases, simply because the sufferers are unable to pay. Intellectual property protection does not provide an incentive to invest in research and development in relation to very neglected diseases. Given that the adoption of the TRIPS Agreement has brought incentives for medical research squarely on the trade agenda, the question of the enjoyment of the right to health of people suffering from neglected diseases has now also become a trade issue.

45. The Special Rapporteur met with representatives of the United Nations Development Programme (UNDP)/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) to discuss these issues. Since his mission, the Special Rapporteur has embarked on research for TDR that examines the human rights dimensions of neglected diseases. These dimensions include: discrimination, the availability and accessibility of essential medicines, the right to enjoy the benefits of scientific progress, and international assistance and cooperation. The Special Rapporteur will provide the Commission on Human Rights and/or General Assembly with a report on this research as soon as possible.

## B. Trade in services and GATS

46. Trade in services can occur through a number of recognized “modes” of supply. Each of these supply “modes” are relevant to the delivery of health and health-related services, and thus to the right to health. For example:

(a) *Cross-border supply (mode 1)*: the supply of a service across a border where both the service providers and the consumer do not leave their respective countries, e.g. offering telemedicine services over the Internet;

(b) *Consumption abroad (mode 2)*: the consumption of a service in one country by a consumer from another country, e.g. a Thai patient travelling to Cuba to receive specialized treatment;

(c) *Commercial presence (mode 3)*: a service supplier offering a service in another country through, for example, a subsidiary, e.g. a Singapore corporation investing in hospital services in Malaysia through a subsidiary;

(d) *Presence of natural persons (mode 4)*: people temporarily entering another country in order to provide a service, e.g. a Filipino nurse offering nursing services in France for a limited period.

47. The liberalization of trade in services across each of these "modes" of service supply opens the health sector to higher levels of international competition. The effect of the liberalization of these "modes" of service supply on health and health-related services will depend on the specific nature of a country's national health system, the regulatory environment, the Government's policies and the level of development and infrastructure of the country. While accepting that increased trade in health services could increase available resources and improve the state of health care in some cases, it could also lead to regressions in enjoyment of the right to health. For example, increasing opportunities for telemedicine (mode 1), attracting wealthy overseas patients for specialized surgery (mode 2), or increasing foreign direct investment in health services (mode 3) might provide needed resources to improve health infrastructures - yet it might also gear health provision towards wealthy local and foreign patients, leading to a two-tier health system that caters to the healthy and wealthy rather than the poor and sick. At times, the public health system can also neglect the poor and people traditionally suffering from discrimination and social injustice; however, in the experience of the Special Rapporteur, these issues are highlighted in the case of higher levels of private participation in services provision.

48. A two-tier system could lead to specialized surgery responding to profitable areas (for example, elective surgery); "cream skimming", where services are provided to those who can pay more but need less; the "brain drain", with health-care professionals moving towards the higher paying private sector focused on patients who can pay, and possibly diverting resources from rural and primary health care towards specialized centres.[11] Thus, while increased trade in services might lead to an improvement in health services for some, it could also generate increased discrimination in the provision of health services - particularly discrimination on the basis of social status - and a withdrawal of resources from the poor towards the wealthy.

49. This is the situation that a human rights approach to trade in services can help to avoid. While some trade and development theorists accept that there will be some "losers" in the process of trade liberalization and development, but this can be justified through overall gains to welfare,[12] a human rights approach focuses on protecting the rights of all, particularly the potential "losers", and seeks to design policies accordingly. The right to health requires that health facilities, goods and services shall be accessible and of good quality. If increased trade in services were to lead to a reduction in rural primary health care, or reduced access for the poor because of user-fees, prima facie this would be inconsistent with the right to health. Equally, if increased trade in services were to lead to substandard health facilities, goods and services, this too would prima facie be inconsistent with the right to health.

50. The General Agreement on Trade in Services (GATS) is the first multilateral agreement governing all forms of international trade in services. GATS covers trade in all services, with a few exceptions, and it seeks to establish a multilateral framework of principles and rules for trade in services with a view to the progressive liberalization and expansion of this trade. GATS breaks down trade in services in the four different "modes" of service supply outlined above.

51. General obligations under GATS - such as the most favoured nation principle,[13] promotion of transparency in relation to laws and regulations that affect trade in services, and assurances that regulations affecting trade in services are applied in a reasonable, objective and impartial manner - apply to all trade in services within the scope of the Agreement. However, WTO members also make specific commitments setting out the extent to which they grant market access and national treatment[14] in relation to services trade with other WTO members.

Each country may make commitments - set out in a country-specific schedule - over 11 service sectors, including health. Commitments may be made across the four modes of service supply outlined above. Thus, each WTO member may commit to the liberalization of trade in services according to the pace it deems appropriate and on the basis of negotiations with other WTO members. Those commitments are, however, subject to further rounds of negotiations to achieve higher levels of market access.[15] The Special Rapporteur notes that commitments and requests for further commitments in the area of health services remain relatively low at the moment.

52. Once a commitment is made, WTO members undertake to introduce no new market access and national treatment restrictions unless those restrictions fall within the general exceptions allowed under GATS.[16] A WTO member may only modify or withdraw a commitment after three years and the WTO member will have to enter into negotiations for compensatory adjustments with any country affected by the modification or withdrawal if requested to do so. The Special Rapporteur questions the appropriateness of the requirement of compensatory adjustments if a decision to modify or withdraw a commitment is linked to the existence of a negative impact on the enjoyment of the right to health. The Special Rapporteur emphasizes the importance of a WTO member undertaking a right to health impact assessment before making a commitment to open up the health service sector to international competition. In this way, the WTO member can decide on the correct form, pace and sequence of trade liberalization according to national needs and consistent with the right to health.

### C. Impact assessments

53. During his mission, the Special Rapporteur found wide support for the general notion of human rights or right to health assessments of trade rules and policies. While a detailed methodology for a right to health impact assessment of trade-related policies has not yet been developed, broadly speaking such an assessment involves a transparent consideration of the likely impact of trade rules and policies on the enjoyment of the right to health and related human rights, undertaken through a participatory process with concerned individuals and groups. Such assessments should have a gender perspective and consider the real and potential effects of the proposed policy on disadvantaged and vulnerable groups. The right to health analytical frameworks outlined in section I might provide a useful way of approaching right to health assessments. Thus, the assessment might consider the likely impact of the policy on the availability, accessibility (in its various forms) and quality of health goods, facilities and services. In some instances, assessments will be needed at three different stages: before, during and after the introduction of the policy or rule. It should be noted that article XIX of GATS mandates the Council for Trade in Services to carry out an assessment of trade in services.

54. On the question of who should carry out assessments, clearly national Governments could play a central role. However, some interlocutors noted the lack of national resources to undertake such studies, which raises the question of both technical assistance and capacity-building (in the WTO context) and international assistance and cooperation (in the human rights context). One possibility is for United Nations country teams to give assistance to national Governments in undertaking human rights impact assessments of trade-related policies.

55. While right to health assessments at the national level are important, the Special Rapporteur recognizes the need to prepare international assessments that provide the global context, or “big picture”. An assessment at the international level could help identify in which

health aspects (essential drugs, the movement of health professionals, water services, etc.), and in which geographical subregions, the international trading regime is leading to improvements and where there are challenges. Read together, national and international assessments could help to identify where international cooperation and assistance is most needed to ensure that the international trading system promotes respect for the right to health in all parts of the world on an equitable basis.

56. Any modern policy maker, unless purely driven by ideology, will wish to consider, in a balanced, objective and rational manner, the likely impact of a proposed new policy, especially on those living in poverty. Too often, ill-considered policies have had disastrous consequences, especially for the poor, who are often left out of policy-making processes even when they are among those most affected. Right to health impact assessments are an aid to equitable, inclusive, robust and sustainable policy-making.

## D. Gender and trade

57. Gender mainstreaming in trade policy - both in making and applying trade rules - requires urgent attention.[17] For various reasons, trade policies and rules can have different implications for men and women. Women and men often have different access to ownership and control of capital, land and other productive resources; this may mean that an apparently neutral trade measure has a different impact on men and women, and this may affect the enjoyment of human rights, including the right to health. For example:

(a) Whether from water-borne diseases or from HIV/AIDS, women often face a disproportionate burden caring for sick family members, reducing their participation in the paid labour force. Trade policies and rules promoting greater access to affordable medicines could have particularly positive outcomes for women, notably with regard to preventing mother-to-child transmission of HIV;

(b) Market access opportunities provided under mode 4 in GATS (movement of natural persons) can affect women and men differently because women constitute a large proportion of health-care personnel. For example, mode 4 liberalization might have a disproportionately positive effect on women health workers in sending countries: more nurses may be able to find short-term employment in countries that have undertaken commitments in this area. However, this may mask structural inadequacies in the receiving country, such as low wages that fail to attract receiving country nationals - and the flow of health workers out of the sending country may have a negative impact on health services in that jurisdiction;

(c) In many States, women and girls have primary responsibility for fetching water. In these countries, if the liberalization of water services improves or hinders physical access to water, then women and girls will be affected disproportionately.

58. Asia-Pacific Economic Cooperation established a Gender Focal Point Network in 2003 to encourage consideration of gender issues within the organization. At the international level, the Special Rapporteur notes the Inter-Agency Task Force on Gender and Trade led by the United Nations Conference on Trade and Development (UNCTAD), and he welcomes the round table on gender equality, trade and development that was sponsored by the Government of Canada in Cancún, Mexico, in September 2003. The Special Rapporteur also welcomes the

interest of the WTO Director-General, delegates and staff who participated in a session on women and trade in June 2003 - the first meeting of its kind in a WTO symposium.[18]

## E. Technical assistance

59. The WTO secretariat undertakes technical cooperation and capacity-building activities to assist developing countries in their efforts to implement WTO rules and procedures. At Doha in 2001, Ministers decided that technical assistance and capacity-building were core elements of the development dimension of the multilateral trading system - in particular to promote more effective participation in trade negotiations, implementation of WTO Agreements and the formulation of trade-related policy - and they made various commitments that members revised in December 2002. Since then, WTO has significantly increased its focus on - and funds available for - technical assistance and capacity-building. For example, the WTO secretariat works closely with officials from UNCTAD and the International Trade Centre (ITC) through the Joint Integrated Technical Assistance Programme to help African country partners benefit from the multilateral trading system. WTO, together with the World Bank, IMF, UNDP, UNCTAD and ITC, participates in the Integrated Framework for Trade-Related Technical Assistance (IF) which is designed to assist the least developed countries (LDCs) in developing the necessary analytical and policy framework for mainstreaming trade into national development strategies.

60. A State's human rights commitment to international assistance and cooperation resonates with a WTO member's commitment to technical assistance and capacity-building in the context of trade. These are two mutually reinforcing international commitments.

61. Technical assistance in the area of trade is a possible vehicle for ensuring that progressive liberalization of trade is conducive to the progressive realization of the right to health. This is not to say that international organizations providing assistance in the area of trade should give technical assistance on human rights. The United Nations has its own technical assistance programme in this regard. However, it is important that technical assistance in one area take into account States' obligations in other areas, including the right to health.

62. During discussions, several interlocutors claimed that WIPO had been giving "TRIPS plus" technical assistance to developing countries, e.g. assisting States draft patent laws that do not fully take into account the flexibilities in the TRIPS Agreement. The Special Rapporteur also notes that such concerns have been raised independently by civil society.[19] Subsequently, a representative of WIPO provided information on its activities in the area of cooperation for development, including advisory services on intellectual property strategies, technical assistance in modernizing intellectual property infrastructure, and so on. WIPO is also engaged in joint technical cooperation activities with WTO. WIPO explained that it provided advice on flexibilities in the TRIPS Agreement, but that it did not have a mandate to interpret that Agreement. WIPO also highlighted that its technical assistance programme responds to requests from developing countries and that it provides advice on options available under the TRIPS Agreement, but that it left experts at the national level to decide which option(s) to implement.

63. In any event, the Special Rapporteur highlights the importance of flexibilities in WTO Agreements as potential means of promoting the right to health, while at the same time implementing trade rules. States may specifically request technical assistance to enable them to

use those flexibilities that are legitimately available to them. Also, since impact assessments have a crucial role to play in the formulation and implementation of equitable trade and health policies, States may request joint UN-WTO technical assistance so that they have the capacity to prepare right to health impact assessments. Further, technical assistance could be requested to help a State ensure consistency between its trade and right to health law. Finally, technical assistance could be requested to help a State identify and establish devices that enhance its policy coherence in relation to trade, health and human rights.

## F. Trade Policy Review

64. WTO members undertake periodic peer reviews of individual member's trade policies through the Trade Policy Review Mechanism (TPRM). Members established TPRM to facilitate the smooth functioning of the multilateral trading system by, inter alia, improving the quality of public and intergovernmental debate on WTO obligations and the general impact of trade policies. All WTO members are subject to review under TPRM, although the frequency of review depends on the share of world trade of the member under review. The review, while undertaken by WTO members in the Trade Policy Review Body, is conducted on the basis of a report provided by the member under review and a report prepared by the WTO secretariat, which is usually prepared after a country mission. The reports generally contain information on the trade policies and practices of the member. Importantly, the mandate of TPRM specifies that the review should take place against the background of the wider economic and developmental needs, policies and objectives of the member concerned. Such a reference suggests that health considerations could be raised as part of the wider economic and developmental needs, policies and objectives of a WTO member. On the basis of discussions held during the mission, the Special Rapporteur notes that, to date, health considerations have not been systematically included within the review.

65. In the introduction to the present report, the Special Rapporteur emphasizes the problem of "disconnected" Government and the challenge of policy coherence. Policy coherence is difficult to achieve: it demands high-level political commitment and the introduction of a variety of processes and arrangements. The Special Rapporteur suggests that TPRM is one of the devices that could and should, in his opinion, be used to enhance policy coherence in relation to trade and health.

## G. Acceding countries

66. A question of serious concern relates to the level of commitments to trade liberalization undertaken by acceding countries to WTO. As part of the process of accession, would-be WTO members enter into negotiations with existing WTO members to discuss their national trade policies and the level of commitments to trade liberalization they will undertake before they become members of the organization. Interlocutors referred the Special Rapporteur to a recent publication of the Commonwealth Secretariat which concluded that "the process of accession to the WTO is fundamentally flawed".[20]

67. First, acceding countries have sometimes accepted demands that are not required under WTO Agreements - known as "WTO plus" - or have foregone benefits or rights included in WTO Agreements - known as "WTO minus". WHO regards "TRIPS plus" as "a non-technical term which refers to efforts to extend patent life beyond the 20-year TRIPS minimum; limit

compulsory licensing in ways not required by TRIPS; and limit exceptions which facilitate prompt introduction of generics".[21] The term "TRIPS plus" is also used to refer to situations where countries implement TRIPS-consistent legislation before they are obliged to do so. The use of trade pressure to impose "TRIPS plus"-style intellectual property legislation could lead member States to implement intellectual property standards that do not take into account the safeguards and flexibilities included under the TRIPS Agreement, which in turn could constrain States from implementing intellectual property systems that provide adequate policy space for the promotion of the right to health.

68. Second, the process of accession negotiations sometimes leads to demands from stronger WTO members for acceding countries to undertake greater commitments than those made by WTO members of a similar developmental status. The Commonwealth Secretariat study compared commitments to the liberalization of trade in services under GATS made by acceding countries as opposed to those of existing WTO members, and concluded that "at each level of services sectoral classification, the commitments made by acceding countries were far larger than those made by WTO Members".[22] Third, the Special Rapporteur is concerned about the situation of recently acceding countries that are under pressure to undertake further commitments to trade liberalization in the current round of trade negotiations launched at Doha while they are still implementing and adjusting to the commitments they undertook during the accession process.

69. The Special Rapporteur reiterates his opinion that international human rights law is neither for nor against any particular trade rule or policy, subject to two conditions.[23] However, he is concerned that pressure in trade negotiations, particularly when exercised by stronger trading partners over smaller acceding countries, might lead to unsustainable commitments to trade liberalization that, in practice, diminish States' capacity to realize the right to health. Powerful States have a human rights responsibility of international assistance and cooperation in relation to the right to health which means, inter alia, that they should respect the obligation of an acceding State to realize the right to health of individuals in its jurisdiction. In other words, during accession negotiations, the various human rights responsibilities of all parties should be kept in mind. At root, human rights remain a check against the possible misuse of power.

## III. RECOMMENDATIONS

70. **The main aim of the Special Rapporteur's mission was modest: to enhance the quality of dialogue between the human rights/right to health and trade communities. The Special Rapporteur hopes that the mission and report will help to establish a secure foundation on which others can build. He remains ready to continue discussions with all interested parties and proposes to keep these issues under review.**

### General recommendation

71. **The Special Rapporteur strongly recommends that dialogue between the human rights/right to health and trade communities be not only deepened, but extended to include the numerous Agreements and issues that space and time did not permit the Special Rapporteur to consider. This dialogue should be supported by research on issues such as the relationship between international human rights law and trade law.**

**The Commission on Human Rights**

72. ***Designing a methodology for right to health impact assessments*. The Special Rapporteur recommends that urgent attention be given to the development of a methodology for right to health impact assessments in the context of trade.**

73. ***A report on the human rights implications of the Agreement on Technical Barriers to Trade (TBT) and the Agreement on Sanitary and Phytosanitary Measures (SPS)*. The Commission could consider requesting a report on the human rights implications of TBT and SPS.**

74. ***A report on technical assistance*. The Commission could consider requesting a report on how the technical assistance provided by OHCHR, WTO, WHO and WIPO could ensure that the progressive liberalization of trade is most conducive to the progressive realization of the right to health.**

75. ***A report on the relationship between trade, poverty and human rights*. The Commission could consider requesting a report on the relationship between contemporary poverty reduction strategies, trade liberalization and the enjoyment of human rights, including the right to health.**

76. ***Establishing guidelines on trade issues for treaty bodies*. The Commission could consider requesting the preparation of guidelines to assist treaty bodies to raise pertinent trade issues in the periodic reporting process.**

**Special rapporteurs**

77. **In appropriate cases, special rapporteurs and other Charter-based independent human rights experts, when carrying out their responsibilities such as country missions, should consider the impact of trade policies and rules on human rights, including the right to health.**

**Treaty bodies**

78. **United Nations human rights treaty bodies should give due attention to trade policies and rules in the discharge of their responsibilities, including their examination of State party reports and the preparation of general comments and recommendations.**

**WTO members**

79. ***Promoting policy coherence*. States should establish effective mechanisms within government that enhance policy coherence between health, human rights and trade. When formulating their trade policies, all States must take into account their national and international human rights obligations, including those relating to the right to health. Developed States must take into account their human rights responsibility of international assistance and cooperation.**

80. ***Right to health impact assessments*. If a State chooses to engage in trade liberalization in those areas that impact upon the right to health, then it should select the**

**form, pacing and sequencing of liberalization that is most conducive to the progressive realization of the right to health for all, including those living in poverty and other disadvantaged groups. The form, pacing and sequencing of liberalization should be selected on the basis of right to health impact assessments.**

81. ***Promoting access to affordable drugs*. Several provisions in the TRIPS Agreement, such as article 31 (compulsory licensing), have significant potential for the protection of the public interest in areas bearing upon the right to health. The Special Rapporteur encourages WTO member States to place these provisions in national legislation as a way of safeguarding aspects of the right to health.**

82. ***Promoting intellectual property legislation consistent with human rights obligations*. The Special Rapporteur recommends that States be cautious about enacting "TRIPS plus" legislation without first understanding the impact of such legislation on the protection of human rights, including the right to health. Equally, wealthy countries should not pressure a developing country to implement "TRIPS plus" legislation, unless reliable evidence confirms that such legislation will enhance enjoyment of the right to health in the developing country.**

83. ***Trade Policy Review Mechanism*. When a member is under review, its Ministry of Health should prepare a paper, if necessary with appropriate technical support from WHO, on the key trade and health issues in that country. This paper should be fed into the TPRM process, as well as providing the basis for a discussion between the Ministries of Health and Trade. Generally, WTO and WHO should deepen their discussions and cooperation on these issues. For example, WHO should be invited to join the country mission which is undertaken as part of the TPRM process.**

84. ***Request for technical assistance in the context of the right to health*. In the context of the Integrated Framework, a member's Ministry of Health should prepare a paper, with appropriate support from WHO, on the country's technical assistance and capacity-building requirements in relation to trade and health. For example, the paper could consider whether the member requires advice and draft legislation on the TRIPS flexibilities. In appropriate cases, this paper might be a revised version of the TPRM paper signalled in the preceding paragraph.**

85. ***International responsibilities in accession negotiations*. Consistent with the human rights concept of international assistance and cooperation, acceding States should not be placed under undue pressure from more powerful States to enter into commitments that are "TRIPS plus" or "WTO plus". Also, an acceding country, with technical assistance where appropriate, should make use of right to health impact assessments before identifying the most appropriate commitments for its particular context.**

**International organizations**

86. ***Respect for members' human rights obligations*. International organizations must be respectful of members' national and international human rights obligations. The organizations' various policy initiatives - commissions, research projects, etc. - should take into account the relevant human rights obligations of their members. Organizations should take steps to ensure that their secretariats understand the main features of human rights law.**

87. ***Mainstreaming a gender perspective*. In making or applying trade policies or rules at the national or international level, the Special Rapporteur underlines that it is important to include women in, and ensure a gender perspective on, these processes. He recommends training on the gender analysis of trade rules and flows, and in methods of collecting sex-disaggregated trade and trade-related data. Further, he recommends that the UNCTAD-led Inter-Agency Task Force on Gender and Trade (or one of its member organizations) convene a conference to examine the actual and potential gender-differentiated impact of trade liberalization. The conference might also consider the most useful role that WTO, and other organizations, could play in gender and trade issues.**

88. ***Promoting the use of flexibilities in trade rules through technical cooperation*. The Special Rapporteur encourages WTO, WIPO and WHO to include advice on TRIPS flexibilities in their technical assistance programmes.**

89. ***Effective measures to address the human rights problem of neglected diseases*. The Special Rapporteur recommends that all parties, especially States and intergovernmental organizations, urgently endeavour to identify effective and sustainable measures to address the serious human rights problem of neglected diseases.**

**Civil society**

90. **The Special Rapporteur recommends that civil society, while campaigning for the integration of the right to health into all national and international policy-making processes that relate to trade, give particular attention to the development of participatory mechanisms (especially for the poor), right to health impact assessments, and effective accountability mechanisms.**

**Notes**

[1] The Special Rapporteur recommends the High Commissioner's reports on: TRIPS (E/CN.4/Sub.2/2001/13), agriculture (E/CN.4/2002/54), GATS (E/CN.4/Sub.2/2002/9), investment (E/CN.4/Sub.2/2003/9), and non-discrimination (E/CN.4/2004/40).

[2] Some NGOs are also encouraging States to integrate human rights into their trade, economics and development policies, e.g. 3D-Trade, Human Rights, Equitable Economy. See www.3dthree.org.

[3] This position has also been adopted by the Committee on Economic, Social and Cultural Rights in general comment No. 3, paragraph 8, and in the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, paragraph 6.

[4] Preliminary report of the Special Rapporteur, (E/CN.4/2003/58, paras. 10-21).

[5] Constitutional Court of South Africa, case CCT 8/02, paragraph 135 (2) (a).

[6] See e.g. Appellate Body Report, *EC - Measures Affecting Meat and Meat Products (Hormones)*, WT/DS26/AB/R, WT/DS48/AB/R; Appellate Body Report, *EC - Measures Affecting Asbestos and Asbestos-Containing Products*, WT/DS135/AB/R.

[7] There is a growing literature on the relationship between human rights and trade law, recent additions including Marceau, "WTO Dispute Settlement and Human Rights", EJIL (2002), vol. 13, No. 4, pp. 753-814, and Howse and Mutua, "Protecting Human Rights in the Global Economy", ICHRDD, Canada, 2002. Also see Leader, "Human Rights, International Trade, and Competing Values: Mapping the Terrain", in Macrory and Appleton (eds.), *Understanding the WTO: Perspectives from Law, Politics, and Economics*, Kluwer, 2004 (forthcoming).

[8] This section draws upon the preliminary report of the Special Rapporteur (E/CN.4/2003/58, paras. 22-36).

[9] For a helpful discussion on the differences - and similarities - between the two principles see E/CN.4/2004/40.

[10] CESCR general comment No. 14, paragraph 12. It should be noted that CESCR has a fourth very important component - *acceptability*. For present purposes, the Special Rapporteur is reading this component into the first dimension (non-discrimination) of the second component (*accessibility*).

[11] R. Chanda, "Trade in health services", *Bulletin of the World Health Organization*, vol. 80, No. 2, 2002, pp. 158-163.

[12] See, e.g. D. Ben-David, H. Nordstrom and L.A. Winters, *Trade, Income Disparity and Poverty*, WTO Special Study No. 5, Geneva, 2000.

[13] GATS, article II (1) provides that "With respect to any measure covered by this Agreement, each Member shall accord immediately and unconditionally to services and service suppliers of any other Member treatment no less favourable than that it accords to like services and service suppliers of any other country."

[14] GATS, article XVII (1) provides that "In the sectors inscribed in its Schedule, and subject to any conditions and qualifications set out therein, each Member shall accord to services and service suppliers of any other Member, in respect of all measures affecting the supply of services, treatment no less favourable than that it accords to its own like services and service suppliers." National treatment and most-favoured nation treatment are the two elements of the trade principle of non-discrimination.

[15] GATS, article XIX (1).

[16] GATS, article XIV.

[17] See, e.g. M. Williams, *Gender Mainstreaming in the Multilateral Trading System*, Commonwealth Secretariat, London, 2003.

[18] Report: http://www.wto.org/english/tratop_e/dda_e/symp03_cida_e.doc.

[19] See, e.g. C. Correa, *Intellectual Property Rights, the WTO and Developing Countries*, Third World Network, London, 2000.

[20] R. Grynberg, V. Ognivtsev and M.A. Razzaque, *Paying the Price for Joining the WTO*, Commonwealth Secretariat, London, 2002, p. 39.

[21] WHO, "Globalization, TRIPS and access to pharmaceuticals", *WHO Policy Perspectives on Medicines*, No. 3, March 2001, p. 4.

[22] Ibid., p. 39.

[23] See paragraph 11.

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