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Cambodia's Membership in the WTO and the Implications for Public Health

Samnang Chea* and Hach Sok†

BACKGROUND

With an estimated per capita income of USD\$280, Cambodia is the poorest and least developed country in East Asia and one of the poorest in the world. At least thirty-six percent of Cambodia's fourteen million people live on less than fifty cents per day. Half of Cambodia's children under age five are malnourished.¹

Although some improvements have been made in recent years, the health situation in Cambodia may still be the worst in the East Asia region. Figures from the World Health Organization (WHO) show that the infant mortality rate is more than double the regional average rate.² Malaria and tuberculosis cause thousands of deaths per year.³ The incidence of HIV/AIDS infection is growing rapidly and may soon overtake other causes of death.⁴ The complex social and economic conditions that are both causes and effects of health crises make health care a critical challenge facing Cambodia. For example, health problems, which decrease individual worker productivity and impact family finances, have been causally linked to much of the landlessness and extreme poverty in rural areas.⁵

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1. USAID, Cambodia: Activity Data Sheet, *at* <http://www.usaid.gov/pubs/cbj2002/ane/kh/442-002.html> (last visited Apr. 25, 2004); *see also* U.N. DEV. PROGRAMME, HUMAN DEVELOPMENT REPORT: MILLENNIUM DEVELOPMENT GOALS 198 (2003), <http://hdr.undp.org/reports/global/2003/>.

2. World Health Org., Country Health Information Profile: Cambodia, <http://www.wpro.who.int/chips/chip02/cam.htm> (last visited Apr. 25, 2004).

3. *Id.*

4. *Id.*

5. ROBIN BIDDULPH, OXFAM, INTERIM REPORT ON FINDINGS OF LANDLESSNESS AND DEVELOPMENT INFORMATION TOOL (LADIT) RESEARCH SEPTEMBER 1999 TO APRIL 2000 (2000).

With incomes so low, Cambodians look to public health care which promises free service and medicine. However, the country's public health budget is extremely under-funded; in 2003, it was just two dollars (U.S.) per citizen.⁶ Privatization of some public health services has been largely unsuccessful—private hospitals have catered to higher-income people in urban areas while the poorest people, most of whom live in rural areas, have been left behind. Public hospitals are sadly lacking in supplies and staff and offer a very low quality of healthcare. Prices for legitimate supplies of medicine are high for the average Cambodian, giving rise to the smuggling of cheap, counterfeit medicine that has a negative impact on overall population health.

In September 2003, Cambodia was approved to join the World Trade Organization (WTO).⁷ As part of its WTO membership, Cambodia will be required to implement the provisions of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement.⁸ This Agreement outlines a uniform standard for intellectual property protection and requires that member countries give the same protection to nationals of other member countries. Although there are other international treaties that deal with these rights, to date TRIPS is the most comprehensive multilateral agreement on intellectual property and its protection.

To what extent will this Agreement impact the health sector in Cambodia? This Case Study assesses the current situation of the health sector in Cambodia and discusses how this Agreement, and WTO accession in general, will impact public health care.

I. THE CURRENT SITUATION OF CAMBODIA'S HEALTH SECTOR

Data compiled by the WHO show Cambodian public health indicators to be among the worst in the world.⁹ The mortality rate of children under five was 124 per 1000 live births in the year 2000, an appallingly high figure in relation to the estimated mortality rate in the East Asia region of forty

6. MINISTRY OF FINANCE, STATE BUDGET IMPLEMENTATION OF CAMBODIA FOR 2003 (March 2004).

7. Press Release, WTO News, Ambition Achieved as Ministers Seal Cambodia Membership Deal (Sept. 11, 2003).

8. Agreement on Trade-Related Aspects of Intellectual Property Rights, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, art. 27.1, LEGAL INSTRUMENTS—RESULTS OF THE URUGUAY ROUND vol. 31, 33 I.L.M. 81 (1994) [hereinafter TRIPS Agreement], available at http://www.wto.org/english/tratop_e/trips_e/t_agm0_e.htm.

9. See World Health Org., *supra* note 2.

per 1000 live births.¹⁰ In the past three years, the figures have gotten even worse: The 2003 United Nations Development Programme (UNDP) statistics placed the mortality rate for children under five at 138 per 1000 live births.¹¹ The main causes of death for the general population are malaria, acute respiratory infection, tuberculosis, diarrhea, and dengue fever. Gaining fast on those causes is the human immunodeficiency virus (HIV), which has been spreading rapidly in the kingdom. HIV is becoming a factor in the low life expectancy numbers in Cambodia.¹² Life expectancy at birth is estimated at only fifty-four years, about fifteen years less than life expectancy in the region.¹³

These poor health statistics are the result of the myriad problems that Cambodians face. Low levels of income and education are exacerbated by the woeful condition of the country's public health system, particularly in rural areas. The Ministry of Finance's statistics reveal the severe shortages of resources that have afflicted the public health system; for example, in 2003, actual expenditures on health were only about half that of the budgeted level.¹⁴ Correspondingly, up to eighty percent of total health expenditures fell upon individual Cambodians.¹⁵

Access to health services is also limited by the paucity of human resources: The physician-to-population and physician assistant-to-population ratios in Cambodia are lower than those observed in neighboring countries.¹⁶ Additionally, the health infrastructure is minimal.

10. *Id.*

11. U.N. DEV. PROGRAMME, *supra* note 1, at 208.

12. World Health Org., *supra* note 2.

13. World Bank, Cambodia at a Glance,

http://www.worldbank.org/data/countrydata/aag/khm_aag.pdf (last modified Aug. 20, 2003); *see also* World Health Org., Select Health Indications 2001,

<http://www.who.int/country/khm/en/> (last visited Apr. 25, 2004).

14. MINISTRY OF FINANCE, *supra* note 6.

15. *See* World Health Org., *supra* note 13; WORLD BANK, CAMBODIA: PUBLIC EXPENDITURE REVIEW, ENHANCING THE EFFECTIVENESS OF PUBLIC EXPENDITURE (Jan. 1999). Most of these health expenditure take place in the private sector, where wealthier Cambodians are able to pay for visits to private doctors and hospitals. Private pharmacists are the first point of call for most non-emergency cases. For emergency cases, people tend to go directly to state facilities. *See* MINISTRY OF HEALTH, STORY OF THE POTENTIAL ROLE OF THE INFORMAL DRUG PROVIDERS (Apr. 2002).

16. As of 2001, WHO statistics showed that there were about 18,000 employees under the Ministry of Health. Of that, 2000 were doctors, 200 dentists, 600 pharmacists, 8000 nurses, and 3000 midwives. World Health Org., *supra* note 13. Even where personnel exist, the services available may be limited; the low wages of public health workers, for example,

For example, there are fewer than 7700 hospital beds within the public health facilities.¹⁷ Overall, these factors contribute to very low utilization of public health services.

The concept of health insurance was introduced in 1991, but it has not been widely adopted, likely due to its relatively high cost and perceived low quality.¹⁸ Most Cambodians remain unaware of the existence of insurance, while others do not trust this new system. Individuals, even the higher-income urban dwellers, have not been buying health insurance—they are prone to feel that the quality of the current health system is too weak, and they prefer to pay the higher prices for superior health care in neighboring countries, such as Vietnam, Thailand and Singapore. Law and regulation will play crucial roles in making health insurance more readily available and attractive to Cambodian workers. In particular, encouraging companies to provide insurance as a workers' benefit, particularly in emerging industries such as the garment sector, could provide a much needed boost in health care options.

The current weaknesses in both the public and private health care systems mean that seeking health care, particularly for a serious medical condition, can quickly push a middle class family into poverty and a poor family into utter destitution. Low income families and individuals are deterred from using the public sector, even if that is their only option, because the public facilities are plagued with a lack of equipment and medicines and are staffed by underpaid and demoralized employees. This understandable distrust of the public sector has led to a downward spiral of severe underutilization and mounting inefficiency in public health care facilities. The private sector offers more responsive service and allows customers to purchase drugs and treatment on credit, but private practitioners are often heavily dependent upon drug sales to earn their income and therefore over-prescribe.

For people in Cambodia, like those in many developing countries with a large rural population, drugs are often the first and only access to modern medicine. Given that most health dollars are spent out of people's own pockets,¹⁹ access to drug supplies occurs primarily via private practitioners and not through public health institutions. Unfortunately,

typically result in low levels of job commitment and high rates of absenteeism.

17. World Health Org., *supra* note 2.

18. To the extent that health insurance is purchased, it is generally only bought by foreign companies, nongovernmental organizations (NGOs), and international organizations.

19. *See supra* note 15 and accompanying text.

the private sector is poorly regulated, so even this minimum access to medicines is fraught with problems. It is estimated that there are a large number of illegal drug sellers—over seventy percent of all drug shops are unlicensed, and managed by non-pharmacists. The Cambodian government has often pledged to crack down on the illegal drug sellers, but little has been accomplished because of weak enforcement institutions.

II. TRADE LIBERALIZATION'S IMPACT ON POPULATION HEALTH CARE

During the past ten years, Cambodia has taken many steps to open its economic policies and to foster growth and development. In 1994, a medium-term adjustment and reform program aiming to restore macro-economic stability was launched, and a process of institutional strengthening supported by the international community was undertaken. Private sector growth has been promoted and efforts have been made at longer-term structural reforms that would allow sustainable economic growth and poverty alleviation. A liberal investment law was promulgated and trade was liberalized.²⁰

As a result, foreign investment flowed into Cambodia during the first years of those reforms; these investments, in turn, allowed rapid development of some emerging industries, such as the garment industry and tourism. External trade significantly expanded and became the main source of economic growth and job creation.²¹

However, income distribution has been uneven. According to estimates by the Economic Institute of Cambodia (EIC), income disparity between rich and poor is growing, and income disparity is also growing among various provinces.²² Globalization is primarily benefiting higher-income people in urban areas, whereas traditionally poorer people in rural areas are not only seeing fewer benefits but are in a larger sense being left behind as globalization continues.

The fear is that Cambodia's WTO membership will result in even wider income distribution inequalities unless there are clear economic and institutional reforms. According to a recent EIC study on the impact of foreign investment on human development, the poor will likely be unable

20. See HACH SOK, CAMBODIA DEV. RESOURCE INST., *THE ECONOMIC DEVELOPMENT AND REFORM POLICY IN CAMBODIA: CHALLENGES AND PROSPECTS IN THE INTEGRATION PROCESS* (2001).

21. *Id.* at 15.

22. See Phalla Kim, *Cambodia's Economy in the Election Year 2003*, EIC ECON. REV., Sept. 2003, at 13-15, available at <http://www.eicambodia.org/publications/publication.htm>.

to seize the opportunities provided by liberalized trade without government support in implementing strict rules and regulations.²³ This inability is because the poor are often uneducated, and trade liberalization can serve to further expand their vulnerability to exploitation. Furthermore, globalization and economic liberalization have huge impacts on the health sector both in the private and public sector. The EIC study clearly shows that these processes positively contribute to economic growth and promote private sector development. But if private sector development occurs in a vacuum, without concurrent attention to the government's provision of good quality public sector services, poor people will be increasingly worse off as measured by growing income inequality.²⁴

The current lack of funding and physical equipment for the public health sector has meant that health professionals from the public sector have been siphoned off to private health institutions. Quite simply, government-determined wages of public sector health professionals at about USD\$25 per month are not enough when the minimum cost of living is estimated to be at least three times higher.²⁵ Consequently, the public sector health professionals spend only the bare minimum of time in their official positions and do the bulk of their work in private clinics. In addition to the wage issues, public sector health institutions suffer from outdated equipment and government neglect. As a result of low wages and a crumbling health infrastructure, the quality of public health service decreases. To reverse this trend, the Cambodian government must make solid commitments to social and health spending, and it must adequately

23. HACH SOK, CAMBODIA: INVESTMENT POLICIES AND HUMAN DEVELOPMENT 7-11 (U.N. Dev. Programme Trade Initiative Project, Feb. 2004).

24. Hack Sok, *Addressing Social Justice for Economic Development and Democracy*, EIC ECON. REV., Dec. 2003, at 12-15, available at <http://www.eicambodia.org/publications/publication.htm>.

25. EIC has undertaken a study to assess the poverty line and income distribution in Cambodia. The first estimation drawn from this study showed that the minimum cost of living (including basic education for children and health care) of a Cambodian household—composed of husband, wife, and three children—is about USD\$150 per month in the rural areas and USD\$300 in the urban areas. Therefore, the minimum monthly salary or income of both husband and wife should be at least USD\$75 each in the rural areas and USD\$150 each in the urban areas. It is noted that, actually, the Cambodian poverty line definition is fifty cents per day per person, while the World Bank definition is twice as high (still only about USD\$30 per person per month). Critics say that fifty cents per day per person is an extreme poverty line existence—that amount might buy a minimum to eat and to clothe oneself, but would not be sufficient for sending children to school or paying for health care when needed.

regulate public health staff to promote efficiency and dependability. The government has consistently made pledges to increase substantially the public health budget, but in fact, disbursement has been extremely irregular. Indeed, the government routinely spends less than half the public health budget it allocates for a fiscal year and during extraordinary periods, such as an election year, some public health expenditures can drop to as low as twenty percent of budgeted amounts.²⁶ The ministries and public institutions responsible for public health do not have the political clout to wrest consistently its budget from a system of internal government financing that is ruled by patronage and kickbacks.

III. THE IMPACT OF TRIPS ON CAMBODIA'S PHARMACEUTICAL INDUSTRY

The Cambodian drug market is very small, likely due to the public's lack of income necessary to purchase drugs. According to the Ministry of Health figures, drug consumption in Cambodia reached only about USD\$35 million in 2001 (less than USD\$3 per capita). Of that total, forty-three percent was provided free of charge by the government and donors; the remaining fifty-seven percent was paid for by private consumers.²⁷ On the supply side, Cambodia's pharmaceutical industry consists of four small manufacturers. One of those manufacturers produces drugs for HIV/AIDS. All four Cambodian manufacturers produce drugs without any patent. Drugs produced in Cambodian factories are much cheaper than foreign products, yet many Cambodians cannot even afford drugs produced locally. Wealthier Cambodians often prefer more expensive imported drugs for reason of confidence in quality.

Studies are currently underway regarding the possibility of exporting Cambodian drugs to foreign markets. In June 2002, the WTO council responsible for intellectual property approved a decision to extend until 2016 the transition period during which least developed countries (LDCs) do not have to provide patent protection for pharmaceuticals. In the international arena, the discussions leading to this decision have focused on the need to balance intellectual property protection with the need to tackle serious public health problems of developing countries, especially health crises resulting from HIV/AIDS, tuberculosis, malaria, and other epidemics. As an LDC, Cambodia could take advantage of the flexibility of

26. Information from the Ministry of Finance (State Budget Implementation of Cambodia for 1998 to 2003) compiled by the authors and on file with *Yale Journal of Health Policy, Law, and Ethics*.

27. MINISTRY OF HEALTH, *supra* note 15.

the TRIPS Agreement and special treatment for LDCs and encourage the growth of its small drug-producing industry.

Even after the 2016 deadline, there are still flexibilities in TRIPS that will allow LDCs, like Cambodia, to implement the Agreement's provisions related to pharmaceuticals in ways that will continue to benefit their own emerging pharmaceutical industries. Under the original TRIPS Agreement, products made under compulsory licensing, which allows the LDCs to produce generic versions of the medicines under license, must be "predominantly for the supply of the domestic market."²⁸ However, in August 2003, WTO member governments reached a new agreement over intellectual property protection and public health that allows producers under compulsory license to export the pharmaceutical products to foreign markets under certain conditions aimed at safeguarding the legitimate interests of the patent holder.²⁹ Questions to be answered include the cost of obtaining this license and whether Cambodian producers could comply with safeguard clauses imposed by the patent holder.

Beginning in 2016 Cambodia will be expected to enforce the intellectual property requirements mandated by TRIPS. The first major implication of the patent system will be increased costs for drug production and sale. Cambodia has few pharmaceutical enterprises and a low capacity of production. To take the particular example of HIV drugs produced here now, Cambodia can currently manufacture these drugs without patents until 2016. The population has reasonable access to these locally-produced lower-priced drugs, although even these lower-priced drugs are out of the reach of many poor Cambodians. If Cambodia implements the TRIPS Agreement and must purchase a patent license, the first immediate shock will be the increase in the price of the drugs. Very few persons will have reasonable access to these much-needed drugs. Hence, the implementation of the patent system will adversely affect the health sector. Cambodia's government must find ways to maintain a supply of less expensive pharmaceutical products that give at least some possibility

28. TRIPS Agreement, *supra* note 8, at art. 31 (f).

29. World Trade Org., General Council, *Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health*, WT/L/540 (Sept. 1, 2003), available at http://www.wto.org/english/tratop_e/trips_e/implem_para6_e.htm. Technically all WTO member countries are eligible to import under this decision, but twenty-three developed countries are listed in the decision as announcing voluntarily that they will not use the system to import. See Press Release, WTO News, Decision Removes Final Patent Obstacle to Cheap Drug Imports (Aug. 30, 2003).

for the poor to access needed medicines. The precipitous increase in the price of medicine that would follow patent licensing will only encourage the smuggling of cheap or counterfeit products.

Second, there are strong doubts that Cambodia has or will have the resources to stay abreast of new technology and invention. Even after the WTO's transitional period, Cambodia will likely lag behind in the areas of pharmaceutical enterprise and pharmaceutical research and development. Therefore, the implementation of the patent system will not only increase the price of drugs, but also limit the supply of drugs in the country because Cambodia may not have access to the technological means to develop or manufacture newer drugs.

It may benefit Cambodia's government, in conjunction with other less developed WTO members, to strengthen the *Doha Declaration* related to TRIPS and public health for the LDCs, and even seek future concessions to ensure cheap access to new medicines.³⁰ As practical steps to achieve this goal, Cambodia should advocate, in concert with other developing countries, extending the transition period far after 2016 and should seek special licensing prices for least developed members. In the meantime, the Cambodian government must promote national research and development institutions, especially in the area of pharmaceuticals, with the assistance of developed countries.

CONCLUSION

The Cambodian pharmaceutical industry remains nascent, and its growth will largely depend on long-term domestic structural reforms. Most of its drug consumption will thus continue to be imported. Cambodia should thus advocate for international agreements that facilitate cheap import drug prices. In the *Doha Declaration* of November 2001, the WTO ministers stressed that it is important to implement and interpret the TRIPS Agreement in a way that supports public health—by promoting both access to existing medicines and the creation of new medicines. They also issued a declaration on how to help poorer countries that are unable to make medicines domestically to access cheaper generics made under compulsory licensing.³¹ Cambodia should thus seek the enhancement of this declaration.

30. World Trade Org., Doha WTO Ministerial 2001, *Declaration on the TRIPS Agreement and Public Health*, WT/MIN(01)/DEC/2 (Nov. 20, 2001), available at http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm.

31. *Id.*

On the domestic supply side, Cambodia has a lot of potential for development since it is situated in the heart of a fast-growing region of Southeast Asia. As a least developed country member, Cambodia could, depending on the laws of the importing country, export most of its products, including drugs, tariff-free to other WTO members. But these opportunities will only turn into benefits if Cambodian industry is competitive and can meet international demands on price and quality. Under the WTO membership agreements, Cambodia must implement a large number of reforms to strengthen its institutions, particularly legal reforms. Specifically, the WTO requires Cambodia to create national intellectual property laws that would conform to the TRIPS Agreement. If these new laws are implemented properly, Cambodia's government could create a new environment that is conducive to trade, while still respecting intellectual property. Particularly for the health sector, if these new laws can be enforced efficiently, the benefits in better health care would be tangible. For example, a reduction in the amount of counterfeit medicine on the local market would have a strongly positive effect on public health.

New TRIPS provisions could also facilitate a technology transfer that might attract more investment to the Cambodian pharmaceutical industry. An increase in the supply capacity could further reduce the price of drugs—making them more affordable for poorer consumers, while also making Cambodia more competitive in the export market. To achieve this transfer, however, Cambodia must work to develop its R&D capabilities in high-technology, medicine, and biotechnology. Only if these efforts are made will Cambodia fully benefit from the TRIPS Agreement.