The impact of trade and trade & investment agreements on public health from a legal/human rights perspective

Position Paper for PETRA

Tamara K Hervey, Jean Monnet Professor of EU Law, University of Sheffield, and Principal Investigator on *Health Governance after Brexit: Law, Language and Legitimacy* ES/S00730X/1

1. The relationships between trade and health can be positive or negative. Trade offers the promise of increased prosperity with associated health benefits. However, the dissemination of those benefits to all in the relevant societies is far from guaranteed, and histories of colonisation and slavery show that trade can involve exploitation with associated poor health. Trade routes also promote the spread of disease, and the diffusion of unhealthy commodities, associated with non-communicable diseases.
2. The negative effects of trade on health are thus known, but they are imperfectly understood. Trade agreements have taken steps to seek to minimise negative impacts on health in several ways.

What are the main legal principles and provisions in trade and investment agreements used to protect public health and specifically for non-communicable disease (NCD) prevention?

3. Broadly speaking, legal principles and provisions in trade agreements which seek to protect public health may be placed on a spectrum. At one end, the States Parties to the trade agreement retain full control over public health regulation, irrespective of their obligations to open their markets to the other States Party/ies. At the other end, the institutions, rules and practices established by the trade agreement are legally obliged to protect public health.
4. Because trade agreements in essence seek to *open up* markets, and domestic regulation (also known as non-tariff or technical barriers to trade) is, in principle, anathema to that opening up, even the simplest trade agreements do not secure *complete* national control over public health regulation. Lowering or removing tariffs on products (a minimal obligation in a very basic trade agreement) can have positive effects on health, through increasing markets and creating new employment opportunities, hence poverty reduction. Consumers can have access to cheaper health-enhancing products, such as fresh vegetables and fruit. But equally, consumers can have easier access unhealthy commodities, such as tobacco, alcohol, firearms, or ultra-processed food with added sugar or salt.
5. Likewise, opening up markets in services can have indirect positive effects on public health, for instance through increasing investment in health systems, for instance through new health technologies. But equally, trade agreements like the General Agreement on Trade in Services (GATS) can have the effect of 'locking in' privatisation of public services which protect public health (for instance environmental services), exposing the public to risks of market failure, and costs associated with (potential) renationalisation.
6. Thus trade agreements inherently involve risks to health protection, as well as possible benefits.

7. One approach to securing protection for health in trade agreements is to articulate national competence over particular aspects of public health protection. This may be effected through the legal mechanism of a reservation or exclusion clause. An example in the Australia-US Free Trade Agreement is Australia's reservation of 'the right to adopt or maintain any measure with respect to wholesale or retail trade services of tobacco products, alcoholic beverages, or firearms' as 'non-conforming measures'. Non-conforming measures are rules that would otherwise breach the agreement but are explicitly excluded from its scope. Another example is the exclusion of tobacco and alcohol completely from the scope of the Pacific Island Countries Trade Agreement.
8. Trade agreements permit exceptions for non-discriminatory non-tariff measures that would otherwise breach trade rules, so long as these are legitimate and no more trade restrictive than necessary. The legal principle encapsulating this concept is sometimes known as proportionality. Unlike exclusions, exceptions do not prevent disputes being brought, but they give a ground on which States Parties can defend the legitimacy of their public health provisions. The classic example is Article XX (b) GATT, which permits measures 'necessary to protect … human life or health'. This provision is further specified through other WTO agreements and through the WTO's dispute resolution obligations.
9. Article 2.2 of the WTO's Agreement on Technical Barriers to Trade (TBT) provides that States Parties must ensure that mandatory requirements concerning product characteristics ('technical barriers to trade') must not be more restrictive of trade than necessary to meet a legitimate objective, such as human health protection.
10. Similarly, the health measures of Article XX (b) GATT have been elaborated in the WTO Agreement on Sanitary and Phytosanitary Measures (SPS) . Under Article 2.4 of the SPS Agreement, if a measure is in conformity with the SPS Agreement, it is presumed to be in conformity with the GATT. The wide definition of sanitary and phytosanitary measures in Article A SPS requires 'scientific' justification for many health protective domestic measures, including 'end product criteria; processes and production methods; testing, inspection, certification and approval procedures; quarantine treatments …; provisions on relevant statistical methods, sampling procedures and methods of risk assessment; and packaging and labelling requirements directly related to food safety'.
11. For food, the Codex Alimentarius Intergovernmental Organization sets a minimum level of acceptable risk to human health through food. Although the Codex works through guidelines, codes and standards, which are technically non-binding, in practice they are a reference point for binding domestic food law, and EU food law too. The Codex standards have become a benchmark in the WTO dispute settlement processes, so the apparent 'floor' of Codex standards in effect 'becomes the trade barrier ceiling which countries cannot exceed without providing rigorous scientific proof' (Gleeson and Labonté, 2020: 14).
12. Questions about how to interpret exceptions clauses are resolved through whatever dispute resolution process is provided for in the relevant free trade agreement. Binding dispute resolution rules are found in WTO system, and also in most newer bi- or multi-lateral free trade agreements.
13. These trade dispute resolution processes are typically not particularly health protective. Where trade agreements involve non-transparent dispute resolution, it is, of course, difficult to be sure. Of the WTO examples discussed in Gleeson and Labonté (2020: 16-20, 75-76), only the asbestos/glass fibres France/Canada dispute and the tobacco plain packaging/Australia dispute were resolved in a health protective way. In others, such as retread tyres/Brazil; 'turkey tails'/Samoa; and alcohol labelling/Thailand, the domestic rules seeking to protect public health were found to be in breach of WTO rules.
14. In the EU system, dispute resolution rules have even deeper effects, because the EU treaties allow private actors to use domestic courts and the EU courts for dispute resolution. This approach can have negative effects for health, through proportionality

control of domestic non-tariff barriers/technical barriers to trade (known as 'mandatory requirements' or 'objective public interest justifications' in EU law). The Court of Justice of the EU (CJEU) originally was willing to accept domestic approaches to public health protection, especially where the international science was disputed. But over time, the CJEU has repeatedly found that health-protective rules are a disproportionate restriction on trade (Hervey and McHale 2015: 404-408).

15. At the same time, however, the CJEU held from the 1970s that human health protection was not only a matter for Member States' competence, but also that human health is *protected by EU law*. As the EU itself has set public health standards in a range of areas, particularly food and medicines safety, the CJEU has become less willing to accept *national* public health protection measures, and has found that these are not justified (Hervey 2012).
16. That said, if governments have closely justified scientific reasons for health-protective non-tariff barriers, these are accepted within the EU system. An example is the *Scotch Whisky Association* litigation, where the specific data on Scottish public health needs were sufficient to demonstrate that a minimum pricing rule would be justified on public health grounds, despite the rule's negative effects on access to the Scottish market.
17. In general, the relationship between trade and health is conceptualised in international trade agreements as a rule/exception relationship (Hervey in Hervey et al 2017: 465). This is problematic from the point of view of global health policy activists – why should trade be the rule and health the exception?
18. The Treaty on the Functioning of the European Union (TFEU) – arguably the deepest example of a trade agreement, though arguably more than just a trade agreement between the 27 Member States of the European Union – includes a 'mainstreaming' obligation (Articles 9 and 168 (1) TFEU), to the effect that the Union is obliged to take human health protection into account in the definition and implementation of all its policies, including both its internal and external trade policies. The mainstreaming obligation goes some way to inverting the rule/exception formulation between trade and health.
19. The 'mainstreaming' obligation resonates with policy coherence obligations found in the UN's 2030 Agenda for Sustainable Development, particularly Sustainable Development Goal 17.
20. Many trade agreements include non-binding provisions stating that their aim is to improve human well-being in various ways. Recital 7 of the Marrakesh Agreement, founding the WTO, is a case in point. It provides that 'the field of trade … should be conducted with a view to raising standards of living, ensuring full employment and a large and steadily growing volume of real income and effective demand, … while allowing for the optimal use of the world's resources with the objective of sustainable development …'. But this provision is not an enforceable part of the agreement. Ultimately, making legal rather than aspirational, the notion that liberalisation of trade is not an end in itself, but only the means to an end, which could include improved public health, would be necessary to secure better protection for public health in trade agreements.
21. Another very different kind of example of an international agreement which adopts the approach of placing health protection centrally in its aims is the WHO Framework Convention on Tobacco Control (FCTC). Although this is not a trade agreement, its existence has featured in dispute settlements involving trade agreements, for example the WTO dispute involving Australia's plain packaging tobacco regulations. The approach of the binding FCTC could potentially be adopted in the context of other products that are harmful to health and responsible for non-communicable diseases, where existing rules are currently in non-binding forms of codes, resolutions and standards.

How should human and social rights be incorporated in trade and health agreements and mechanisms?

22. Health and human rights are complementary approaches to defining and promoting human thriving and well-being (Mann, Gostin et al 1994; Murphy 2013). Thinking about health as a human right emphasises health as a collective social good. The notion of health rights also emphasises individual enforceability of rights.
23. 'Human and social rights conditionality' is a feature of more recent trade agreements. These agreements include clauses requiring States Parties to respect human rights, labour rights, or environmental obligations as part of the trade agreement. Such clauses play two main roles: they reaffirm shared values, and they express conditional access to markets, based on the protection of those values. Conditionality provisions become enforceable if a State Party lowers their human rights protections in order to gain a trade or investment advantage. But they also play a role in securing domestic change during the process of negotiating the trade agreement, and the mere threat of use may ensure compliance through diplomatic processes, through open and constructive inter-state dialogue, especially if such clauses include regular reporting requirements.
24. Some free trade agreements refer only to domestic labour standards: the legal form of such provision is along the lines of States Parties 'shall not fail to effectively enforce' labour laws. Others refer to International Labour Organization (ILO) standards, particularly the ILO Declaration of Fundamental Principles and Rights at Work. This covers freedom of association and collective bargaining, elimination of forced labour, abolition of child labour, and elimination of employment discrimination.
25. Likewise, free trade agreements refer to international environmental agreements, such as the Convention on Biological Diversity, the Convention on International Trade in Endangered Species of Wild Flora and Fauna, the Cartagena Protocol on Biodiversity, the Montreal Protocol on Substances that Deplete the Ozone Layer, the Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and their Disposal, or the Convention on Persistent Organic Pollutants.
26. Occasionally, trade agreements involve exclusions that protect environmental rights and standards, such as the EU-Canada Comprehensive Economic and Trade Agreement's (CETA) exclusion of 'water in its natural state'.
27. At the level of principle, the Treaty on the Functioning of the European Union includes a general respect for 'the right to health', as found in the EU's Charter of Fundamental Rights.
28. The provisions on human/labour/environmental rights in trade agreements tend to be relatively weak, often not subject to dispute resolution, and not setting binding specific externally measurable standards. Their application is usually excluded in 'export processing zones' (specially designated economic areas in low and middle income countries, with weak taxation and regulatory measures, for example, prohibition of unionization, designed to attract foreign investment). There are stronger provisions in the United States-Mexico-Canada Agreement (USMCA) (not (yet) ratified) obliging States Parties to 'implement policies that protect workers against employment discrimination on the basis of sex, including with regard to pregnancy, sexual harassment, sexual orientation, gender identity, and caregiving responsibilities'. The Treaty on the Functioning of the EU gives power to the EU institutions to adopt 'measures to ensure the application of the principle of equal opportunities and equal treatment of men and women in matters of employment and occupation', and several relevant EU laws have been adopted on this basis, which bind the EU Member States, and are enforceable by individuals against their employers. This approach is unique in international trade law.

29. Another aspect of trade law adopted in the EU which could be indirectly beneficial for health through protecting labour and/or environmental rights is the EU's approach to government procurement. This permits tendering processes to require a 'social clause' ensuring that human rights are not harmed. Other free trade agreements on procurement could adopt this approach.
30. The US-Korea trade agreement requires application of some environmental standards in export processing zones. The EU-Bosnia & Herzogovena and EU-Montenegro agreements required ratification of the Kyoto Protocol on Climate Change.
31. Attempts to secure access to essential medicines are embodied in the flexibilities associated with the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS flexibilities). This approach secures lesser obligations for middle/lower income countries in the interests of public health. It arose through economic, political and legal pressure surrounding access to drugs for HIV/AIDS, particularly in South Africa. We may see similar mobilisation of NGOs and civil society around access to treatments for COVID-19 and/or a vaccine (see Médicins Sans Frontières 2017 concerning lack of access to new vaccines in low/middle income countries).

What research and development gaps are there?

32. Although some studies exist, in general the effects of different types of trade and trade & investment agreements on health is insufficiently understood.
33. We lack detailed evidence to secure pro-public health outcomes in dispute settlement processes involving non-tariff barriers. This is one of the things that may explain the differences between outcomes on tobacco policies compared to outcomes in the context of alcohol and food policies. The relatively weak evidence base on the public health effects of particular policies (eg taxation, pricing, labelling, health warnings) 'creates uncertainties that may deter countries from introducing innovative mandatory measures' (Gleeson and Labonté, 2020: 77-78).
34. We lack studies on the effects, especially on public health in low and middle income countries, of the general move over time, away from WTO-based trade negotiations towards the 'spaghetti bowl' (Baier et al 2008) of bi- and multi-lateral trade and trade & investment agreements.
35. We lack transparent data on the effects of particular trade agreements on health, and associated indirect health indicators, particularly relative poverty (measured for instance by the Gini coefficient), employment, and sustainable development.
36. There is a desperate paucity of public discussions, based on transparency, of the trade-offs inherent in trade agreements and their associated effects on health. Trade negotiation is not seen as the domain of health policy experts and other relevant stakeholders. A 'many eyes' approach would enhance the legitimacy of governments seeking to enter into trade agreements.
37. To summarise ' … too little attention has been given to known or potential health risks associated with trade and particularly trade that is governed by complex modern trade rules' (Gleeson and Labonté, 2020: 5).

References

Baier, S L, J H Bergstrand, P Egger, P A McLaughlin 2008 ‘Do Economic Integration Agreements Actually Work? Issues in Understanding the Causes and Consequences of the Growth of Regionalism’ *The World Economy* 461-497.

Gleeson, D and R Labonté 2020 *Trade Agreements and Public Health* (Singapore: Palgrave Macmillan).

Hervey, T K 2012 ‘The Role of the European Court of Justice in the Europeanization of Communicable Disease Control: Driver or Irrelevance?’ 37. (6) *Journal of Health Politics Policy and Law* 975-998.

Hervey T K and J V McHale (2015) *European Union Health Law: Themes and Implications* (Cambridge: Cambridge University Press).

Hervey, T K 2017 ‘The EU’s (emergent) global health law and policy’ in T K Hervey, C A Young and L E Bishop, *Research Handbook on EU Health Law and Policy* (Cheltenham and Northampton MA: Edward Elgar) 453-478.

Mann J, L Gostin et al 1994 ‘Health and Human Rights’ 1 *Journal of Health and Human Rights* 7-14.

Médicins Sans Frontières 2017 *A fair shot for vaccine affordability: understanding and addressing the effects of patents on access to newer vaccines* https://msfaccess.org/fair-shot-vaccine-affordability Accessed 15 July 2020.

Murphy T 2013 *Health and Human Rights* (Oxford and Portland OR: Hart).