Maryland Journal of International Law

Volume 25 | Issue 1 Article 9

In Search of Coherence Between Trade and Health: Inter-Institutional Opportunities

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In Search of Coherence Between Trade and Health: Inter-Institutional Opportunities*

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The fragmented state of contemporary international law and institutions gives rise to contentious relationships between larger policy objectives. An example of such relationships—the "trade and health" debate—has long been understood as suffering from a lack of policy coherence, at the expense of health. This Article explores the institutional modalities of formulating a coherent policy that would redress the gravitational pull of the World Trade Organization (WTO), examining opportunities for cooperation between the major relevant international organizations. Part II of the Article notes the multi-layered impacts of trade on health, mindful of areas of tension between trade agreements and health. Then, in Part III, these tensions are placed within the broader discourse about the fragmentation of international law into sectoral normative regimes, with a view to highlighting the major risks involved in the process. Part IV briefly addresses the impact of trade agreements on national health measures and the operation of the "health exception" in the General Agreement on Tariffs and Trade (GATT) 1994 in light of the jurisprudence of WTO tribunals. Part V explores the role of the World Health Organization (WHO) in the governance of trade and

*The authors would like to thank Constantinos Salonidis and Tania Voon for their comments on an earlier draft of this article.

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health. The Article concludes by making suggestions for formal inter-institutional cooperation between the WTO and the WHO, which, it is hoped, would positively contribute to the development of norms and institutional practices that better integrate legitimate health objectives into trade policy making and implementation, and legitimate trade objectives into health policy making and implementation.

I. INTRODUCTION

In early 2009, the *Lancet*, one of the world's leading health journals, published a six-part series on trade and health. The series introduction noted that "trade directly and indirectly affects the health of the global population with an unrivalled reach and depth . . . ."[1] It argued that trade is a "key health issue that the global-health community can no longer ignore"[2] and called on health professionals "to become engaged in the fight for a fairer trading system so that health has a chance of being considered as important as wealth."[3] The publication and framing of the series by the *Lancet* reflect a concern among leading members of the global health community that the links between trade and health are not well enough understood—let alone addressed—within the field. The perception is of a lack of "policy coherence" between trade and health, at the expense of health.

Such concerns about policy incoherence between trade and health are best analysed within a wider context. They form part of a much larger discourse about the fragmentation of international law and of the practice of international institutions. Concerns about trade and health reflect two specific manifestations of this broader discourse: perceptions of a crisis in global health governance; and the so-called "trade and ———" debates, which involve an examination of the links—and possible conflicts—between trade objectives and those of a range of other areas of domestic and international activity, including the environment, human rights, conditions of labour, and culture.[4] These "trade and ———" debates raise major questions

1. Rhona MacDonald & Richard Horton, *Trade and Health: Time for the Health Sector to Get Involved*, 373 LANCET 273, 273 (2009).

2. *Id.*

3. *Id.* at 274.

4. Jeffery Atik, *Health*, *in* THE OXFORD HANDBOOK OF INTERNATIONAL TRADE LAW 597–98 (Daniel Bethlehem et al. eds., 2009) ("To a certain degree, the WTO-and-health debates mirror anxieties about the compatibility of environmental,

about the power of the World Trade Organization (WTO), its sensitivity to other important (nontrade) values, and its role and influence in the governance of both international and domestic affairs.

Building on the existing literature on the tensions between trade and health and aiming at contributing to suggestions for better managing them, this Article argues for inter-institutional cooperation processes that would maximize the benefits and minimize the risks of fragmentation. Part II notes the broad, multi-layered impacts of trade on health and areas of tension between trade agreements and health, focusing on public health measures designed to prevent noncommunicable diseases. Part III places these tensions within the broader context of fragmentation generally and the more specific context of fragmentation of global health governance and seeks to identify some of the major risks of fragmentation. Part IV briefly sketches the treatment of health in several WTO Agreements, including the health exception in the General Agreement on Tariffs and Trade[5] (GATT) 1994 and the General Agreement on Trade in Services[6] (GATS) and explains the problem of "regulatory chill," which is caused by uncertainty about the impact of these trade agreements. Part V explores the role of the World Health Organization (WHO) in the governance of trade and health and makes some suggestions for formal inter-institutional cooperation between the WTO and the WHO. It argues that such cooperation should ultimately lead to the development of norms and institutional practices that better integrate legitimate health objectives into trade policy making and implementation and legitimate trade objectives into health policy making and implementation. The benefits of such integration would be seen in improvements in both global health and global economic development.[7]

labour and human rights protections with WTO norms.").

5. General Agreement on Tariffs and Trade 1994, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1A, Multilateral Agreements on Trade in Goods, 1867 U.N.T.S. 187, 33 I.L.M. 1154 (1994) [hereinafter GATT].

6. General Agreement on Trade in Services, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1B, 1869 U.N.T.S. 183, 33 I.L.M. 1167 (1994) [hereinafter GATS].

7. For discussion of the links between health and development, see World Health Organization [WHO], *Investing in Health: A Summary of the Findings of the Commission on Macroeconomics and Health*, *available at* http://www.who.int/

II. THE IMPACT OF TRADE AND TRADE AGREEMENTS ON HEALTH

A. *The Impacts of Trade on Health*

Cross-disciplinary, international work conducted over the last decade has illustrated the many ways in which people's health is determined by their social conditions. In 2005, the WHO established a Commission on Social Determinants of Health, which published in 2008 its final report, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*.[8] The Commission concluded that "the high burden of illness responsible for appalling premature loss of life arises in large part because of the conditions in which people are born, grow, live, work, and age—conditions that together provide the freedom people need to live lives they value."[9] Conditions that negatively impact on health include lack of income, economic insecurity, inappropriate housing, unsafe workplaces, and lack of access to health care.[10]

If health is determined by such a broad range of social conditions, trade must affect health in multiple ways and on multiple levels, both "direct" and "indirect." Direct links between trade and health include damage caused by trade in harmful goods (such as goods contaminated by pathogens and goods containing dangerous substances) and the effects of liberalising trade in health-related services.[11] Indirect links between trade and health include trade's influence on employment levels and income through its effects on macroeconomic conditions.[12] As Anna Shea, Nancy Ross, and Jody Heymann observe, the fact that poverty and inequality exert negative effects on people's health means that understanding how trade policies affect health requires an analysis of their impacts on poverty

macrohealth/infocentre/advocacy/en/investinginhealth02052003.pdf. *See also* R Dodd & A. Cassels, *Health, Development and the Millennium Development Goals*, 100 ANNALS TROPICAL MED. & PARASITOLOGY 379 (2006).

8. *See* WHO, Comm'n on Soc. Determinants of Health, *Closing the Gap in a Generation: Health Equality Through Action on the Social Determinants of Health* (2008) [hereinafter WHO, CSDH Final Report], *available at* http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf.

9. *Id.* at 26 (citation omitted).

10. Ronald Labonte, Ted Schrecker & David Sanders, *Trade Policy and Health Equity: Can They Avoid a Collision?*, *in* TRADE AND HEALTH: SEEKING COMMON GROUND 226, 226 (Chantal Blouin, Jody Heymann & Nick Drager eds., 2007).

11. David P. Fidler, Nick Drager & Kelley Lee, *Managing the Pursuit of Health and Wealth: The Key Challenges* 373 LANCET 325, 328–29 (2009).

12. *Id.* at 329.

and equality.[13]

At the macro level, theory suggests that trade should improve people's health by enhancing the capacity of societies to produce goods and services, in turn increasing the capacity of governments to adjust to change, protect their interests, and invest in people's well-being.[14] David Fidler suggests that:

> Trade could even be considered a geopolitical determinant of health that requires the support and backing of public health as a matter of foreign policy. A weak or failing international trading system would produce political and economic consequences under which national and global health, especially of the most vulnerable populations, would suffer.[15]

In contrast, a "stable, orderly, and dynamic international trading system . . . delivers economic opportunities and resources that are critical for improving standards of living, funding public services, and supporting good governance."[16]

The economic development impact of globalization in general and trade liberalization in particular has been widely studied. Not surprisingly, the empirical realities are complex and often contested. Shea, Ross, and Heymann argue that the best evidence offered by cross-national studies "demonstrates that economic globalization's effects have been highly variable across populations and outcomes."[17] So too with trade liberalisation. It is widely accepted that trade liberalization alone is insufficient to boost economies.[18] In several countries, it has not translated into economic expansion.[19] Complementary measures that create a stable macroeconomic environment, competitive exchange rate, solid fiscal policies, well-functioning agricultural and labour markets, and physical

13. Anna Shea, Nancy Ross, & Jody Heymann, *Trade, Inequalities, and Health: Making the Important Measurable*, *in* TRADE AND HEALTH: SEEKING COMMON GROUND 202, 207 (Chantal Blouin, Jody Heymann, & Nick Drager eds., 2007).

14. *Id.* at 203.

15. David P. Fidler, *Achieving Coherence in Anarchy: Foreign Policy, Trade and Health*, *in* TRADE AND HEALTH: SEEKING COMMON GROUND 294, 311 (Chantal Blouin, Jody Heymann & Nick Drager eds., 2007).

16. *Id.*

17. Shea, Ross & Heymann, *supra* note 13, at 212.

18. Chantal Blouin, Mickey Chopra & Rolph van der Hoeven, *Trade and Social Determinants of Health*, 373 LANCET 502, 503 (2009).

19. *Id.*

infrastructure are needed to ensure that trade openness leads to a high level of growth.[20]

With respect to people's health, as Shea, Ross, and Heymann highlight, the distribution of wealth within a society is critical—it is levels of poverty and inequality that matter most.[21] The "social gradient" in health affects people in rich and poor countries alike, with low socioeconomic status in all countries being related to poor education, lack of amenities, unemployment and job insecurity, poor working conditions, and unsafe neighbourhoods.[22] These outcomes are not necessarily improved when a nation's trade regime is liberalised,[23] especially where trade liberalization is not accompanied by governance reforms. The authors highlight "suggestive cross-national and national evidence showing that increased trade can lead to worsened levels of poverty, inequality, and by extension, well-being."[24] In every society, trade reforms create winners and losers.[25]

B. *The Impact of Trade Agreements on Governments' Capacity to Promote and Protect Health*

The negotiation and adoption of trade agreements (be they multilateral, plurilateral, or bilateral) have been at the heart of the rapid process of liberalisation that has unfolded over the last fifty years. The adoption of these agreements has seen the elimination or reduction of a wide range of barriers to trade, both tariffs and "nontariff barriers to trade," which include trade-discriminatory laws, policies, and programmes. New goods and services have flooded into markets all over the world. Multinational corporations have expanded their operations, entering markets that had previously been closed to them. The effects on economies and cultures have been

20. *Id. See also* John H. Jackson, *International Economic Law: Complexity and Puzzles* 10 J. INT'L ECON. L. 3, 8 (2007) ("While liberal trade policies have been important enhancers of citizen welfare in some countries, it is becoming clearer that such trade policies alone will most often not have a welfare enhancing effect."). Jackson lists a number of factors which can prevent economic progress, including lack of peace and security, lack of market infrastructure, bad governance, health, education, skills, attitudes, lack of human rights and societal stress due to large inequalities of economic status. *Id.* at 8–9.

21. Shea, Ross & Heymann, *supra* note 13, at 219.

22. WHO, CSDH Final Report, *supra* note 8, at 31.

23. Shea, Ross & Heymann, *supra* note 13, at 219–20.

24. *Id.* at 220.

25. Blouin, Chopra & van der Hoeven, *supra* note 18, at 503. *See also* Shea, Ross & Heymann, *supra* note 13, at 220.

extraordinary.

Within the large field of study and debate about trade and health, one area that has received considerable attention, both in academic literature and domestic and international political fora, has been the effects of trade agreements on governments' prerogative to freely choose and develop their political, social, and cultural systems, in particular their capacity to implement laws, policies, and programmes to promote and protect public health. Concerns that governments have ceded too much sovereignty in striking such agreements have been expressed.[26] Albeit at times somewhat exaggerated, the discourse also points to the "democratic deficit" in the WTO, which undermines the capacity of the organization to represent the will of the citizens of its members.[27] The *Lancet* series includes articles on two of the most contentious areas: the impact of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)[28] on access to medicines[29] and of the GATS on the provision of health services.[30]

Another area of significant academic and political discussion has been the impact of trade agreements on global efforts to reduce the burden of noncommunicable diseases.[31] This is an area likely to gain

26. Fons Coomans, *Sovereignty Fading Away? Prioritizing Domestic Health Needs Versus Promoting Free Trade*, *in* CHANGING PERCEPTIONS OF SOVEREIGNTY AND HUMAN RIGHTS: ESSAYS IN HONOUR OF CEES FLINTERMAN 123, 125–26 (Ineke Boerefijn & Jenny E. Goldsmith eds., 2009).

27. Andrew D. Mitchell & Elizabeth Sheargold, *Global Governance: The World Trade Organization's Contribution*, 46 ALBERTA L. REV. 1061, 1075–76 (2009).

28. Agreement on Trade-Related Aspects of Intellectual Property Rights, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, 1869 U.N.T.S. 299, 33 I.L.M. 1197 (1994) [hereinafter TRIPS].

29. *See* Richard D. Smith, Carlos Correa & Cecilia Oh, *Trade, TRIPS, and Pharmaceuticals*, 373 LANCET 684 (2009).

30. *See* Richard D. Smith, Rupa Chanda & Viroj Tangcharoensathien, *Trade in Health-Related Services*, 373 LANCET 593 (2009).

31. *See, e.g.*, Benn McGrady, *Trade and Tobacco Control: Resolving Policy Conflicts Through Impact Assessment and Administrative Type International Laws*, 3 ASIAN J. WTO & INT'L HEALTH L. & POL'Y 341 (2008) [hereinafter McGrady, *Trade and Tobacco Control*]; Benn McGrady, *Trade Liberalisation and Tobacco Control: Moving from a Policy of Exclusion Towards a More Comprehensive Policy*, 16 TOBACCO CONTROL 280 (2007) [hereinafter McGrady, *Trade Liberalisation and Tobacco Control*]; Allyn L. Taylor et al., *The Impact of Trade Liberalization on Tobacco Consumption*, *in* TOBACCO CONTROL IN DEVELOPING COUNTRIES 343 (Prabhat Jha & Frank Chaloupka eds., 2000); Cynthia Callard, Hatai Chitanondh & Robert Weissman, *Why Trade and Investment Liberalisation May Threaten Effective Tobacco Control Efforts*, 10 TOBACCO CONTROL 68

in prominence over the coming years, with increasing recognition of the scale of the burden and understanding of its causes and momentum building internationally for concerted action to reduce it. In 2008, the World Health Assembly (WHA) endorsed the *2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases* (Action Plan).[32] The Action Plan records that noncommunicable diseases—principally cardiovascular diseases, diabetes, cancers, and chronic respiratory diseases—caused an estimated thirty-five million deaths in 2005.[33] This constituted sixty percent of all deaths globally, with eighty percent of these occurring in low- and middle-income countries.[34] Projections show that the total deaths from noncommunicable diseases will rise by seventeen percent over the next ten years, disproportionately affecting poor and disadvantaged populations and

(2001); Douglas Bettcher & Ira Shapiro, *Tobacco Control in an Area of Trade Liberalisation*, 10 TOBACCO CONTROL 65 (2001); Donald W. Zeigler, *International Trade Agreements Challenge Tobacco and Alcohol Control Policies*, 25 DRUG & ALCOHOL REV. 567 (2006), *available at* EBSCOhost Academic Search Premier, AN 23243788; Robin Room, *International Control of Alcohol: Alternative Paths Forward*, 25 DRUG & ALCOHOL REV. 581 (2006), *available at* EBSCOhost Academic Search Premier, AN 23243792; Ben Baumberg & Peter Anderson, *Trade and Health: How World Trade Organization (WTO) Law Affects Alcohol and Public Health*, 103 ADDICTION 1952 (2008), *available at* EBSCOhost Academic Search Premier, AN 35118782; Roger S. Magnusson, *Non-communicable Diseases and Global Health Governance: Enhancing Global Processes to Improve Health Development*, 3 GLOBALIZATION & HEALTH 2 (2007) [hereinafter Magnusson, *Non-communicable Diseases and Global Health Governance*] (on obesity), *available at* http://www.globalizationandhealth.com/content/3/1/2; Roger S. Magnusson, *Rethinking Global Health Challenges: Towards a 'Global Compact' for Reducing the Burden of Chronic Disease*, 123 PUB. HEALTH 265 (2009) [hereinafter Magnusson, *Rethinking Global Health Challenges*] (same), *available at* EBSCOhost Academic Search Premier, AN 38507776; Blouin, Chopra & van der Hoeven, *supra* note 18 (same); Anne Marie Thow and Corinna Hawkes, *The Implications of Trade Liberalization for Diet and Health: A Case Study from Central America*, 5 GLOBAL HEALTH 5 (2009), *available at* http://www.globalzatio nandhealth.com/content/5/1/5.

32. World Health Assembly [WHA], Sixty-first Assem., Geneva, Switz., May 19–24, 2008, *Summary Records of Committees–Reports of Committees—Resolution of the 61st World Health Assembly–Prevention and Control of Noncommunicable Diseases: Implementation of the Global Strategy*, WHA61.14, WHA61/2008/REC/ 3 (May 24, 2008), *available at* http://apps.who.int/gb/ebwha/pdf_files/WHA61-REC1/A61_REC1-en.pdf.

33. WHO, *2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases*, at 9 (2008) [hereinafter Action Plan], *available at* http://whqlibdoc.who.int/publications/2009/9789241597418_eng.pdf.

34. *Id.*

contributing to widening health gaps between and within countries.[35] Noncommunicable diseases are thus "*closely linked to global social and economic development*."[36] Tackling the growing burden "constitutes one of the major challenges for development in the twenty-first century."[37]

As the Action Plan makes clear, noncommunicable diseases are largely preventable. Key to their prevention is reducing the level of exposure of individuals and populations to their four common risk factors—tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol.[38] Roger Magnusson argues that consumption of tobacco and overconsumption of alcohol and unhealthy foods (foods high in fat, salt, and/or sugar) reflect "the success of global business enterprises that seek to manipulate consumer behaviour for profit and to resist measures that could reduce consumption."[39] Regulating the behaviour of these entities is an essential part of comprehensive prevention programmes and is bound to generate debate about consistency with international trade obligations.

III. FRAGMENTATION OF INTERNATIONAL LAW AND INTERNATIONAL INSTITUTIONS

A. *The Causes of Fragmentation*

As noted in Part I, concerns about incoherence between trade and health are best viewed within the wider context of concern about the fragmentation of international law and of the practice of international institutions. In the Report of the Study Group of the International Law Commission on *Fragmentation of International Law: Difficulties Arising from the Diversification and Expansion of International Law*, Martti Koskenniemi explains that, while globalisation "has led to increasing uniformization of social life around the world, it has also led to its increasing fragmentation—that is, to the emergence of specialized and relatively autonomous spheres

35. *Id.*
36. *Id.* at 13.
37. *Id.* at 9.
38. *Id.* at 10.
39. Magnusson, *Rethinking Global Health Challenges*, *supra* note 31, at 268. *See also* Fidler, *supra* note 15, at 321; Derek Yach & Robert Beaglehole, *Globalization of Risks for Chronic Diseases Demands Global Solutions*, 3 CHRONIC DISEASES & GLOBAL SOLUTIONS 213, 220 (2004), *available at* EBSCOhost Academic Search Premier, AN 14578875.

of social action and structure."[40] This "fragmentation of the international social world has attained legal significance especially as it has been accompanied by the emergence of specialized and (relatively) autonomous rules or rule-complexes, legal institutions and spheres of legal practice."[41]

A number of factors have been identified as contributing to the "fractious state of the international legal system,"[42] including: the proliferation of norm-creating and norm-influencing international institutions or expansion of the mandate of existing ones; the increased emphasis on and prominence of regionalization; technology-driven global changes giving rise to new areas of regulation; global environmental challenges; the greater prominence of and recognition of individual rights, internationally, regionally, and nationally;[43] the lack of centralized organs; the specialization of regulations; and the different structures of legal norms.[44]

Fragmentation, however, "is not necessarily a bad thing."[45] Specialization in law making and law enforcement can lead to better law.[46] Competition between institutions can increase efficiency and provide opportunities for the development of new legal instruments.[47] New forms of cooperation among intergovernmental bodies with different institutional strengths can be generated, and new venues in which states can bargain and link issue areas can be created.[48] Analysis of complex problems from different perspectives and from

40. Int'l Law Comm'n, Fifty-eighth Sess., Geneva, Switz., May 1–9 & July 3–Aug. 11, 2006, *Fragmentation of International Law: Difficulties Arising from the Diversification and Expansion of International Law— Report of the Study Group of the International Law Commission*, para. 7, U.N. DOC, A/CONF.4/L.682 (Apr. 13, 2006) (*finalized by* Martti Koskenniemi) [hereinafter Int'l Law Comm'n Report], *available at* http://untreaty.un.org/ilc/guide/1_9.htm.

41. *Id.* para. 8 (citation omitted).

42. Victor Mosoti, *Institutional Cooperation and Norm Creation in International Organizations*, *in* HUMAN RIGHTS AND INTERNATIONAL TRADE 165, 167 (Thomas Cottier, Joost Pauwelyn & Elisabeth Bürgi Bonanomi eds., 2005).

43. *Id.*

44. Gerhard Hafner, *Pros and Cons Ensuing from Fragmentation of International Law*, 25 MICH. J. INT'L L. 849, 854–55 (2004).

45. Joost Pauwelyn, *Bridging Fragmentation and Unity: International Law as a Universe of Inter-Connected Islands*, 25 MICH. J. INT'L L. 903, 904 (2004).

46. *Id.*

47. *Id.*

48. Laurence R. Helfer, *Regime Shifting: The TRIPs Agreement and New Dynamics of International Intellectual Property Lawmaking*, 29 YALE J. INT'L L. 1, 82 (2004).

within different professional, political, and institutional cultures can facilitate creative thinking and allow for the development and implementation of innovative approaches.

B. *Fragmentation in Global Health Governance*

In the public health field, scholars have become increasingly concerned about the fragmented nature of global health governance. Pronounced fragmentation in this field is perhaps inevitable given the breadth of the determinants of health. For example, "[p]olicies outside the health sector, in areas such as trade, the environment, and education, are becoming drivers of health and health risks."[49] Thus, "[h]ealth problems are no longer 'only' health problems and are no longer the domain of 'only' health officials."[50] Writing about noncommunicable diseases, Magnusson points out that "[e]ffective regulation of the structural and environmental determinants requires interventions that extend well beyond the health sector"[51] with policy influence required in areas such as agriculture, finance and taxation, education, recreation and sports, media and communication, transportation, and urban planning.[52]

In health, as in other areas of policy, fragmentation in governance at the domestic level feeds upwards to the international level. Thomas Cottier, Joost Pauwelyn, and Elisabeth Bürgi argue that the problem of coordination:

> starts with the lack of adequate domestic policy coordination within governments. Problems faced on the international level between international organizations often merely reflect the fact that governments are equally fragmented . . . . Ministries and departments are competing in the pursuit of their policy briefs, and supported by different constituencies in society.[53]

At the international level, Allyn Taylor identifies the "diversity of

49. Diana Chigas et al., *Negotiating Across Boundaries: Promoting Health in a Globalized World*, *in* TRADE AND HEALTH: SEEKING COMMON GROUND 325, 326 (Chantal Blouin, Jody Heymann & Nick Drager eds., 2007).

50. *Id.*

51. Magnusson, *Non-communicable Diseases and Global Health Governance*, *supra* note 31, at 3 (citation omitted).

52. *Id.* at 3–4 (citation omitted).

53. THOMAS COTTIER, JOOST PAUWELYN, & ELISABETH BÜRGI, *Linking Trade Regulation and Human Rights in International Law: An Overview*, *in* HUMAN RIGHTS AND INTERNATIONAL TRADE 1, 10 (2005).

intergovernmental organizations [that] now contribute to the elaboration of the increasingly complex and multivaried field of international health law,"[54] including the WHO, the United Nations Children's Fund (UNICEF), the Food and Agriculture Organization of the United Nations (FAO), the United Nations Environment Programme (UNEP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the World Bank, the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Commission for Human Rights (now the Human Rights Council), and the WTO.[55] Lawrence Gostin and Allyn Taylor note the "growing evidence of fragmentation, duplication and inconsistency in areas of global health law-making . . . [and that] [t]he proliferation of actors and institutions [in] the field of global health law is not serving to strengthen global health governance, but rather is leaving the field in disarray."[56] Importantly, as Fidler, Drager, and Lee observe, fragmentation is challenging the "WHO's lead role as the UN specialised agency for health."[57]

Fragmentation at the international level is not, of course, simply a product of domestic fragmentation—it also reinforces it. For example, Fidler describes the process of "transgovernmentalism," under which "stove-piped" government ministries and agencies, increasingly having to manage globalized issues, begin to interact more directly with their counterparts in ministries overseas, often without the benefit of domestic interagency processes.[58] This complicates the process of domestic policy development and defies standards of good governance requiring transparency and

54. Allyn L. Taylor, *Governing the Globalization of Public Health*, 32 J. L. MED. & ETHICS 500, 502–03 (2004) (citation omitted).

55. *Id.* at 503. Other international organizations that could be added to Taylor's list include the United Nations Office on Drugs and Crime (UNODC), the International Atomic Energy Agency (IAEA), and the International Labour Organization (ILO). This combined list remains far from complete, indicating the range of areas of policy that impact either directly or indirectly on health.

56. Lawrence O. Gostin & Allyn L. Taylor, *Global Health Law: A Definition and Grand Challenges*, 1 PUB. HEALTH ETHICS 53, 60 (2008). *See also* Magnusson, *Rethinking Global Health Challenges*, *supra* note 31, at 266–67; Lawrence O. Gostin, *A Proposal for a Framework Convention on Global Health*, 10 J. INT'L ECON. L. 989, 990–91 (2007).

57. Fidler, Drager & Lee, *supra* note 11, at 327.

58. Fidler, *supra* note 15, at 299.

legitimacy.[59] Such "[h]orizontal policy plumbing among finance ministries of various countries might achieve coherence among themselves but to the exclusion of connecting their pipes with the plumbing running to the development or environment ministries."[60]

Thus the search for coherence is a search for coherence at two levels—"external policy coherence" (which involves the balancing of the health and trade interests of different states) and "internal policy coherence" (which involves getting trade and health policy makers to work together more effectively in formulating the national interest).[61] However, the challenges of finding coherence at the domestic and international levels are fundamentally different. As David Leebron points out, "in the domestic context there is virtually always some coordinating mechanism and superior authority (such as the chief executive) to coordinate both the allocation of tasks and the substantive resolution of issues."[62] In contrast, "[a]lthough various international organizations have mechanisms for cooperating with each other, these relationships are generally neither hierarchical nor comprehensive."[63]

C. *The Risks of Fragmentation*

As noted above, fragmentation is not, in itself, a good thing or a bad thing. Rather, it is a fact of political and legal life with both positive and negative features. The governance challenge is to maximize the opportunities that it offers and minimize its harms.

In order to do so, it is necessary to be mindful of the major risks that it creates. At the international level, these include the development of potentially conflicting norms by different institutions, creating either the impossibility of complying with both sets of norms or significant uncertainty about how states, institutions, and their individual representatives should behave;[64] the development of conflicting institutional practices (including in programs that seek to implement or facilitate the implementation of norms);[65] the failure of

59. Mitchell & Sheargold, *supra* note 27, at 1064.
60. Fidler, *supra* note 15, at 300.
61. *See id.* at 299, 306.
62. David W. Leebron, *Linkages*, 96 AM. J. INT'L L. 5, 8 (2002).
63. *Id. See also* Fidler, *supra* note 15, at 314; Hafner, *supra* note 44, at 854.
64. *See* Int'l Law Comm'n Report, *supra* note 40, para. 14; Mosoti, *supra* note 42, at 168.
65. Int'l Law Comm'n Report, *supra* note 40, para. 14.

institutions to learn from and make use of the expertise of other institutions, diminishing the quality of their work;[66] inter-institutional tensions and turf wars;[67] and inefficient duplication of activities of different institutions.[68]

IV. THE GOVERNANCE OF HEALTH THROUGH THE WTO AGREEMENTS

A. *Trade's Perceived Dominance*

The "battle" between trade and health values and governance arrangements is played out on many different levels and in many different fora. At the domestic level, it can be observed in the development and implementation of both trade and health policy, in the development of government trade negotiation positions, and in the implementation of obligations under trade agreements. At the international level, it is acted out in the negotiation of trade agreements by states—whether multilateral, plurilateral, or bilateral—and in the oversight of implementation by the parties to these agreements, including the various formal and informal exchanges they may have at different levels of government about their respective rights and obligations and levels of compliance. It is also played out—perhaps most prominently—through formal dispute settlement processes, such as under the WTO's Understanding on Rules and Procedures for the Settlement of Disputes (DSU).[69]

Scholarship in the public health field tends to express a perception that health does poorly in its "battles" with trade. In domestic settings, Fidler writes that "trade ministries typically have more power within governments than health ministries . . . ."[70] This manifests itself particularly acutely in the setting of trade policy, in light of the "low status that health policy receives compared with the status of commercial interests in the setting of trade policy."[71] Public-interest groups tend to exert less weight than industry lobbyists in

66. Mosoti, *supra* note 42, at 173.
67. *Id.* at 168.
68. *Id.*
69. Understanding on Rules and Procedures Governing the Settlement of Disputes, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 2, 1869 U.N.T.S. 401, 33 I.L.M. 1226 (1994) [hereinafter DSU].
70. Fidler, *supra* note 15, at 315.
71. Kelley Lee, Devi Sridhar & Mayur Patel, *Bridging the Divide: Global Governance of Trade and Health*, 373 LANCET 416, 418 (2009).

setting priorities and shaping the international trade agenda.[72] This absence of health representation in trade policy is particularly pronounced in low- and middle-income countries.[73]

This imbalance at the domestic level both shapes and is fuelled by the international mechanisms for governing trade and health. Fidler, Drager, and Lee argue that comparing these mechanisms "reveals why trade has so far dominated governance of this relationship."[74] They contrast global health governance, with its limited structural coherence, greater diversity of actors, and approaches and weaker legal obligations on states, with the "highly structured, formalised, and demanding governance system" of international trade.[75] In contrast to the WTO, membership in the WHO "is not legally demanding on states," and other international agreements directly affecting health have not contained extensive duties or detailed and specific requirements.[76] The "scope and demanding nature" of the WTO rules is reinforced through its compulsory dispute settlement mechanism, under which trade sanctions may be applied.[77] The WHO's two legally binding instruments—the International Health Regulations (IHR)[78] and the WHO Framework Convention on Tobacco Control (FCTC)[79]—do not contain compulsory dispute settlement and enforcement provisions. They "thus lack the compliance bite that WTO rules have. This difference could affect how seriously countries take obligations connected to the two organisations."[80] Further, the proliferation of regional and bilateral

72. *Id.*
73. *Id.*
74. Fidler, Drager & Lee, *supra* note 11, at 327.
75. *Id.*
76. *Id.* at 328. *See also* Gostin & Taylor, *supra* note 56, at 60.
77. Fidler, Drager & Lee, *supra* note 11, at 328. *See also* Pauwelyn, *supra* note 45, at 905. Article 22 of the DSU sets forth procedures aiming at inducing compliance with Dispute Settlement Body rulings and recommendations. DSU, *supra* note 69, art. 22. Article 23 establishes the compulsory character of the dispute settlement mechanism envisaged by the DSU. *Id.* art. 23.
78. WHO, Fifty-eighth Sess., Geneva, Switz., May 16–25, 2005, *Revision of the International Health Regulations*, WHO Res. WHA58.3 (May 23, 2005) [hereinafter WHO IHR], *available at* http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf.
79. WHO Framework Convention on Tobacco Control, May 21, 2003, 2302 U.N.T.S. 166, 42 I.L.M. 518 [hereinafter WHO FCTC].
80. Fidler, Drager & Lee, *supra* note 11, at 328. *See also* Gostin & Taylor, *supra* note 56, at 60.

trade agreements,[81] which create a complex web of obligations and dispute settlement mechanisms that are impossible to monitor at the global level and therefore to respond to in a systematic way, "reinforces international trade law's dominant governance role in the trade and health arena."[82]

B. *Balancing Trade and Health in the WTO Agreements*

Health does feature prominently in the WTO agreements. Article XX of GATT and Article XIV of GATS both contain exceptions that allow members to implement domestic measures that are "necessary" to protect human health, as long as they are not applied "in a manner which would constitute a means of arbitrary or unjustifiable discrimination between countries where [the same[83]/like[84]] conditions prevail, or a disguised restriction on international trade . . . ."[85] The Agreement on Technical Barriers to Trade[86] (TBT Agreement) and the Agreement on the Application of Sanitary and Phytosanitary Measures[87] (SPS Agreement) both affirm the right of WTO members to take measures necessary for the protection of human health, while seeking to prevent the creation of unnecessary obstacles to international trade.

For example, under the TBT Agreement, technical regulations are not to be "more trade-restrictive than necessary to fulfill a legitimate objective, taking account of the risks non-fulfilment would create."[88] Legitimate objectives explicitly include "protection of human

81. *See generally* BILATERAL AND REGIONAL TRADE AGREEMENTS: COMMENTARY AND ANALYSIS (Simon Lester & Bryan Mercurio eds., 2009). The WTO contains a regional trade agreements database on its website. *See also* WTO, Regional Trade Agreements Gateway, http://www.wto.org/english/tratop_e/regi on_e/region_e.htm (last visited Mar. 15, 2010).

82. Fidler, Drager & Lee, *supra* note 11, at 328.

83. The words "the same conditions" are used in the GATT.

84. The words "like conditions" are used in the GATS.

85. GATT, *supra* note 5, art. XX; GATS, *supra* note 6, art. XIV.

86. Agreement on Technical Barriers to Trade, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1A, Multilateral Trade Agreements on Trade in Goods, 1868 U.N.T.S. 120, 122 [hereinafter TBT Agreement].

87. Agreement on the Application of Sanitary and Phytosanitary Measures, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1A, Multilateral Trade Agreements on Trade in Goods, 1867 U.N.T.S. 493 [hereinafter SPS Agreement].

88. TBT Agreement, *supra* note 86, art. 2.2.

health."[89]

Aimed at responding to a number of perceived inadequacies in the GATT 1947 discipline of state discretion in their health policy,[90] the conclusion of the Uruguay Round produced the SPS Agreement, which deals with certain health measures.[91] Art 2.1 of the SPS Agreement affirms the right of WTO members to take sanitary and phytosanitary measures[92] necessary for the protection of human health, provided that such measures are not inconsistent with the Agreement. Measures should be applied "only to the extent necessary to protect" health, be based on scientific principles, and not be maintained without sufficient evidence (except for the case of provisional measures, where there is insufficient scientific evidence, and provided certain conditions are met);[93] "not arbitrarily or unjustifiably discriminate between members where identical or similar conditions prevail, including between their own territory and that of other members;"[94] and "not be applied in a manner that would constitute a disguised restriction on international trade."[95] SPS measures that conform to the SPS Agreement are presumed to be in compliance with the WTO Agreements.

89. *See, e.g.*, *id.* pmbl. ("*Recognizing* that no country should be prevented from taking measures necessary to ensure the quality of its exports, or for the protection of human, animal or plant life or health, of the environment, or for the prevention of deceptive practices, at the levels it considers appropriate, subject to the requirement that they are not applied in a manner which would constitute a means of arbitrary or unjustifiable discrimination between countries where the same conditions prevail or a disguised restriction on international trade, and are otherwise in accordance with the provisions of this Agreement; . . .").

90. Atik identifies, as such, the inadequately deferential nature of the 'necessity requirement' in Article XX(b) GATT, the inability of panels to address relevant scientific claims, the lack of harmonization between justified measures under Article XX(b), and the repercussions of the E.C.-U.S. dispute over the use of growth hormones in beef production. Atik, *supra* note 4, at 598–99.

91. For health measures not falling within the ambit of the SPS Agreement, Article XX(b) of GATT remains the relevant provision. *Id.* at 599.

92. These terms are defined in clause 1 of Annex A to the SPS Agreement. SPS Agreement, *supra* note 87, art. 2.1, annex.

93. *Id.* art. 2.2, 5.7.

94. *Id.* art. 2.3.

95. *Id.* art. 2.3. *See also* SPS Agreement, *supra* note 88, pmbl. ("*Reaffirming* that no Member should be prevented from adopting or enforcing measures necessary to protect human, animal or plant life or health, subject to the requirement that these measures are not applied in a manner which would constitute a means of arbitrary or unjustifiable discrimination between Members where the same conditions prevail or a disguised restriction on international trade").

Article 27.2 of the TRIPS Agreement allows members to exclude inventions from patentability where the prevention of commercial exploitation is necessary to protect, inter alia, public health.[96] Article 8.1 contains a principle that members may "adopt measures necessary to protect public health . . . , provided that such measures are consistent with the provisions of th[e] Agreement."[97] The TRIPS Agreement does not contain a health exception as such, and the status of the principle and the requirement for consistency with the terms of the Agreement have been the subject of debate.[98] In the context of disagreement about the effects of the Agreement on access to medicines, the WTO members adopted in 2001 the Declaration on the TRIPS Agreement and Public Health (the Doha TRIPS and Public Health Declaration),[99] which includes the following statements:

> We agree that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health . . . .[100]
>
> . . . .
>
> In applying the customary rules of interpretation of public international law, each provision of the TRIPS Agreement shall be read in the light of the object and purpose of the Agreement as expressed, in particular, in its objectives and principles.[101]

96. TRIPS, *supra* note 28, art. 27.2.

97. *Id.* art. 8.1.

98. *See, e.g.*, Benn McGrady, *TRIPS and Trademarks: The Case of Tobacco*, 3 WORLD TRADE REV. 53, 68 (2004).

99. World Trade Organization, Declaration on the TRIPS Agreement and Public Health of 14 November 2001, WT/MIN(01)/DEC/2, 41 I.L.M. 755 (2002). *See also* Andrew D. Mitchell & Tania Voon, *Patents and Public Health in the WTO, FTAs and Beyond: Tension and Conflict in International Law*, 43 J. WORLD TRADE 571 (2009).

100. *Id.* para. 4.

101. *Id.* para. 5(a). Coomans argues that the statement effectively waived TRIPS requirements that restricted production under compulsory licensing to the domestic market. Coomans, *supra* note 26, at 129. For a discussion of the circumstances of the negotiation and adoption of the Doha Declaration and of the legal status of the declaration, see, for example, James T. Gatthii, *The Legal Status of the Doha Declaration on TRIPS and Public Health Under the Vienna Convention on the Law of Treaties*, 15 HARV. J.L. & TECH. 291 (2002); Ellen 't Hoen, *TRIPS, Pharmaceutical Patents, and Access to Essential Medicines: A Long Way from*

However, the Doha TRIPS and Public Health Declaration appears in practice to be indirectly circumvented by "TRIPS-plus" Free Trade Agreements, which provide higher levels of intellectual property protection than TRIPS and operate outside the context of the WTO.[102] Such agreements will likely exert a significant impact on the availability and accessibility of essential medicines, although it is still too early to confidently assume in this respect.[103]

Returning to the multilateral context, while the value of health is recognized in all of these agreements, the aim in all cases is to strike a balance between trade and health objectives. The need for balance—rather than a hierarchy of importance—between trade and health is not uniquely a product of WTO processes. Indeed, it is also reflected in the WHO's International Health Regulations (IHR), the purpose and scope of which "are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, *and which avoid unnecessary interference with international traffic and trade*."[104]

While balance is an unimpeachable principle, difficulties of course arise when it has to be struck in a particular case. Uncertainty cannot be avoided. As for any subjective decision, the identity of the person or body charged with striking the balance and its sources of information are critical. Public health advocates have expressed concerns about the suitability of trade panels to weigh trade and health values.[105] The understandable concern is that individuals who are expert in trade and likely to be internalized within trade cultures and "epistemic communities" are likely to better understand and place a greater value upon trade values than health values. Baumberg and Anderson point out that the deciding of cases "within opaque panels by experts on trade—although admittedly politically sensitive

Seattle to Doha, 3 CHI. J. INT'L L. 27 (2002); Duncan Matthews, *WTO Decision on Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health: A Solution to the Access to Essential Medicines Problem?*, 7 J. INT'L ECON. L. 73, 81–83 (2004); Andrew D. Mitchell and Tania Voon, *Patents and Public Health in the WTO, FTAs and Beyond: Tension and Conflict in International Law*, 43 J. WORLD TRADE 571, 578–79 (2009).

102. Coomans, *supra* note 26, at 132.

103. *Id.* at 136–41.

104. WHO IHR, *supra* note 78, art. 2 (emphasis added). *See also* Fidler, *supra* note 15, at 307–08.

105. *See, e.g.*, Callard, Chitanondh & Weissman, *supra* note 31, at 69.

trade experts"—can lead to "a feeling that health views are marginalized."[106] This concern is not confined to the "trade and health" equation. For example, Andrew Guzman writes that the resolution of tensions in the relationship between trade and labour standards through the WTO's Appellate Body is undesirable because the Appellate Body is poorly positioned to completely understand the tradeoffs at stake.[107]

In a strict legal sense, neither panels nor the Appellate Body are authorized to "interpret" the WTO agreements; Art IX:2 of the Marrakesh Agreement Establishing the World Trade Organization (Marrakesh Agreement) reserves to the Ministerial Conference and the General Council the "exclusive authority to adopt interpretations of the Marrakesh Agreements and the covered Multilateral Agreements."[108] Furthermore, WTO tribunals and the DSU Dispute Settlement Body (DSB) cannot "add to or diminish the rights and obligations [of members] provided in the covered agreements."[109] In practice, however, "panel and Appellate Body reports are interpreting, elaborating, and consolidating WTO law norms . . . ."[110] Their decisions are pivotal to the way WTO obligations and rights are understood[111] and contribute to greater predictability and security in the dispute settlement system.[112]

C. *The Health Exception in the GATT and the GATS*

The striking of the balance between trade and health values by WTO panels and the Appellate Body has occurred most prominently in their interpretation of the health exception (particularly the word "necessary") found in the GATT and the GATS. It is clear that health

106. Baumberg & Anderson, *supra* note 31, at 1953. *See also* Ronald Labonte & Matthew Sanger, *Glossary of the World Trade Organisation and Public Health: Part 2*, 60 J. EPIDEMIOLOGY & COMMUNITY HEALTH 738, 743 (2006).

107. Andrew T. Guzman, *Trade, Labor, Legitimacy*, 91 CAL. L. REV. 885, 887 (2003).

108. Marrakesh Agreement Establishing the World Trade Organization art. IX(2), Apr. 15, 1994, 1867 U.N.T.S. 154, 159, 33 I.L.M.1144, 1148 (1994) [hereinafter Marrakesh Agreement].

109. DSU, *supra* note 69, art. 3.2.

110. Mosoti, *supra* note 42, at 176.

111. Appellate Body Report, *Japan – Taxes on Alcoholic Beverages*, at 11–13, WT/DS8/AB/R, WT/DS10/AB/R, WT/DS11/AB/R (Oct. 4, 1996); *See also* Richard H. Steinberg, *Judicial Lawmaking at the WTO: Discursive, Constitutional, and Political Constraints*, 98 AM. J. INT'L L. 247, 254 (2004).

112. *See* Appellate Body Report, *US–Final Anti-dumping Duties on Stainless Steel from Mexico*, WT/DS344/AB/R (Apr. 30, 2008).

is treated as an important value in the language of WTO jurisprudence. In 2001, in *European Communities—Measures Affecting Asbestos and Asbestos-Containing Products*, the Appellate Body wrote that the "preservation of human life and health . . . is both vital and important in the highest degree."[113] But a recognition of the importance of health says little about how the balance with trade will be struck either in general or in any particular case.

The jurisprudence on the health exception has evolved over the years, arguably towards an application of the health exception (and other exceptions) that is more accommodating of health (as well as other nontrade) interests than previously. Recent jurisprudence in particular suggests that governments retain a significant degree of policy space.[114] The most recent major Appellate Body decision interpreting the necessity exception, *Brazil—Measures Affecting Imports of Retreaded Tyres*,[115] confirms that WTO members are entitled to set the public health objective they seek to achieve and the level of protection they want to obtain;[116] the determination of necessity involves a "weighing and balancing" exercise;[117] the

113. *See* Appellate Body Report, *European Communities–Measures Affecting Asbestos and Asbestos-Containing Products*, para. 172, WT/DS135/AB/R (Mar. 12, 2001).

114. Of course, this is a matter of judgment, and throughout the evolution of the jurisprudence, different views have been expressed about the amount of policy space it leaves to governments. For the view that significant policy space is reserved, see, for example, Baumberg & Anderson, *supra* note 31, 1954–55; Alyssa Woo, *Health Versus Trade: The Future of the WHO's Framework Convention on Tobacco Control*, 35 VANDERBILT J. TRANSNAT'L. L. 1731, 1763–64 (2002); Debra P. Steger, *Afterword: The "Trade and . . ." Conundrum – A Commentary*, 96 AM. J. INT'L L. 135, 144 (2002); Yach & Beaglehole, *supra* note 39, at 222; Bettcher & Shapiro, *supra* note 1, 65–66. For the alternate view, see, for example, Zeigler *supra* note 31, at 575; Labonte & Sanger *supra* note 106; Callard, Chitanondh & Weissman, *supra* note 31, at 69.

115. Appellate Body Report, *Brazil–Measures Affecting Imports of Retreaded Tyres*, WT/DS332/AB/R (Dec. 3, 2007) [Hereinafter *Brazil–Retreaded Tyres* AB Report]. The interpretation in *Brazil–Retreaded Tyres* is broadly consistent with, and builds on, previous cases, though it may include a stronger recognition of the importance of not treating complementary measures as alternatives. *See also* Benn McGrady, *Necessity Exceptions in WTO Law: Retreaded Tyres, Regulatory Purpose and Cumulative Regulatory Measures*, 12(1) J. INT'L ECON. L. 153, 163–68 (2008).

116. The "right that WTO Members have to determine the level of protection they consider appropriate in a given context[]" is a "fundamental principle."*Brazil–Retreaded Tyres* AB Report, *supra* note 115, para. 210.

117. In order to determine whether a measure is necessary, "a panel must consider the relevant factors, particularly the importance of the interests or values

contribution made by a measure to the achievement of its objective must be material, not merely marginal or insignificant;[118] the contribution made by a measure to the achievement of its objective can be demonstrated by either a qualitative or quantitative analysis;[119] certain complex public health problems can be "tackled only with comprehensive policy comprising a multiplicity of interacting measures";[120] the results obtained from certain actions, including certain preventive actions to reduce the incidence of diseases that may manifest themselves only after a certain period of time, can only be evaluated with the benefit of time;[121] if the weighing and balancing described above yields a preliminary conclusion that a measure is necessary,[122] the result must be confirmed by comparing the measure with possible alternatives identified by the complaining member, which "may be less trade restrictive while providing an equivalent contribution to the achievement of the objective pursued";[123] a member whose measures have been challenged may seek to show that a suggested possible alternative was not in fact "reasonably available";[124] and mutually supportive elements of a comprehensive policy cannot be considered real alternatives.[125]

While the interpretation does not strictly "prioritize" health "over" trade, it does appear to seek a reasonable balance, enabling governments' public health objectives to outweigh trade objectives where the former meet the requirements of the exception. The Appellate Body's interpretation also acknowledges the complexity

at stake, the extent of the contribution to the achievement of the measure's objective, and its trade restrictiveness." *Id.* para. 178.

118. *Id.* para. 210.

119. *Id.* paras. 146–47, 151.

120. *Id.* para. 151. In the short-term, it may be "difficult to isolate the contribution . . . of one specific measure from those attributable to the other measures that are part of the same comprehensive policy." *Id.*

121. *Id.* (citation omitted).

122. By allowing necessity to be "provisionally" established, Atik notes that the Appellate Body in *Brazil–Retreaded Tyres* "softened" the requirements of Article XX(b). Atik, *supra* note 4, at 614–15.

123. *Brazil–Retreaded Tyres* AB Report, *supra* note 115, para. 156.

124. For example, where the measure is merely theoretical in nature, "for instance, where the responding Member is not capable of taking it, or where the measure imposes an undue burden on that Member, such as prohibitive costs or substantial technical difficulties." *Id.* (citing Appellate Body Report, *United State – Measures Affecting the Cross-Border Supply of Gambling and Betting Services*, para. 308, WT/DS285/AB/R (Apr. 7, 2005)).

125. *Id.* paras. 181, 211.

and inter-relatedness of the multiple elements of comprehensive public health policy as well as the difficulties of precisely quantifying, particularly in advance and in the absence of direct precedent the likely effectiveness of measures sought to be implemented.[126]

D. *Uncertainty and Regulatory Chill*

Even if it is correct that panels and the Appellate Body leave governments significant room to undertake measures to protect public health (and other important values)—and will likely continue to do so—the very fact of justiciability and the inherent uncertainty of the judicial process contribute to what is commonly known as "regulatory chill"—in this context, "the reluctance of governments to introduce domestic public health laws for fear of inviting trade disputes."[127] In the absence of cooperation of all major trade competitors, it is not difficult to imagine that this effect may spill onto the international level as well. This chill is likely to be particularly pronounced in areas where powerful commercial entities have an interest in dissuading governments from acting, such as in the area of noncommunicable disease prevention. Well-resourced companies regularly commission legal opinions from leading domestic and international lawyers that highlight—and have an incentive to overstate—the risks of a successful trade challenge. Even the successful defence of a trade challenge takes significant time and resources, which governments may prefer to allocate elsewhere.

126. To be sure, criticisms have been made of the jurisprudence. For example, Schoenbaum, over a decade ago, argued that the requirement that governments adopt the "'least trade restrictive'" measure reasonably available "turns the clause on its head," with "'necessary'" no longer relating to the objective but to the departure from the trade agreement. Thomas J. Schoenbaum, *International Trade and Protection of the Environment: The Continuing Search for Reconciliation*, 91 AM. J. INT'L L. 268, 276 (1997). This interpretation "constitutes too great an infringement on the sovereign powers of states to take decisions (one hopes) by democratic means so as to solve problems and satisfy their constituents." *Id.* at 277 (citation omitted). McGrady argues that "[n]either the panel nor the Appellate Body has a legitimate role in evaluating the importance of domestic policy goals that fall within the scope of the provision." McGrady, *supra* note 115, at 162 (citation omitted).

127. Magnusson, *Non-communicable Diseases and Global Health Governance*, *supra* note 31, at 8. *See also* McGrady, *Trade Liberalisation and Tobacco Control*, *supra* note 31, at 280; Baumberg & Anderson, *supra* note 31, at 1952; Callard, Chitanondh & Weissman, *supra* note 31, at 69; Ira S. Shapiro, *Treating Cigarettes as an Exception to the Trade Rules*, XXII SAIS REVIEW 87, 94 (2002).

Thus, it is clear that, although health appears to receive relatively good protection in most of the WTO agreements, at least insofar as they are likely to be relevant to noncommunicable disease prevention, there is inevitably a degree of uncertainty about the impact of trade agreements on particular measures that governments may wish to adopt. For those interested in the protection of public health, a key challenge is to build bridges between the systems of trade governance and health governance in order to ensure that the importance—and the facts—of health are sufficiently understood and valued within the governance of trade.

V. IN SEARCH OF COHERENCE

A. *The World Health Organization and the World Trade Organization*

The WHO was established in 1948 with an ambitious objective: "the attainment by all people of the highest possible level of health."[128] The WHO is a UN specialized agency for the purposes of Article 57 of the UN Charter,[129] pursuant to an agreement between the UN and the WHO.[130] The WHO is provided by its Constitution with an extremely broad mandate to protect and promote international health, befitting its designation as the UN specialized agency in the field. It has a wide range of functions, which are set out in Article 2 of its Constitution, including: to act as the "directing and coordinating authority on international health work";[131] to "establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate";[132] to "propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective";[133] to "promote

128. Constitution of the World Health Organization art. 1, July 22, 1946, 62 Stat. 2679, 14 U.N.T.S. 185 [hereinafter WHO Constitution], *available at* http://www.who.int/governance/eb/who_constitution_en.pdf.

129. U.N. Charter art. 57.

130. Agreement between the United Nations and the World Health Organization, Nov.12, 1948, 19 U.N.T.S. 193, *available at* http://apps.who.int/gb/bd/PDF/bd47/EN/cover-and-contents-en.pdf.

131. WHO Constitution, *supra* note 128, art. 2(a).

132. *Id.* art. 2(b).

133. *Id.* art. 2(k).

and conduct research in the field of health";[134] to "provide information, counsel and assistance in the field of health;"[135] to "develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products";[136] and "generally to take all necessary action to attain the objective of the Organization."[137]

The WTO was established in 1994 by the Marrakesh Agreement to "provide the common institutional framework for the conduct of trade relations among its Members in matters related to" a range of agreements.[138] Its functions are set out in Article III of the Marrakesh Agreement.[139] The WTO is intended to facilitate the implementation, administration and operation of the WTO agreements, and negotiations among members concerning their trade relations; to administer the DSU and the Trade Policy Review Mechanism; and to cooperate with other international institutions in global economic policy making.[140]

B. *What Role for the WHO in the Governance of Trade and Health?*

As illustrated in Part I, trade has profound effects on health at multiple levels. The UN specialized agency for international health, with a mandate as broad as that of the WHO, has a clear responsibility to monitor and engage in "trade and health" issues. But it is not clear how or to what extent the WHO should play a role in trade and health governance or how the inevitable overlap between its mandate and that of the WTO should be managed.

At one level, the question about the WHO's role is a broader one about the role it should perform in relation to health-relevant international law making generally, in a world in which, as noted earlier, there is a large "body of international law that powerfully affects global health in areas ranging from food safety, arms control, and the environment to trade and human rights"[141] and beyond. Taylor

134. *Id.* art. 2(n).
135. *Id.* art. 2(q).
136. *Id.* art. 2(u).
137. WHO Constitution, *supra* note 128, art. 2(v).
138. Marrakesh Agreement, *supra* note 108, art. II.
139. *See id.* art. III.
140. *Id.*
141. Gostin, *supra* note 56, at 996.

argues that the WHO "has a unique directive to provide leadership and promote rational and effective development of the evolving field of international health law."[142] This does not mean full centralization of all international health law-making functions under the WHO's auspices[143] but rather "leadership in coordinating codification and implementation efforts among the diverse global actors actively engaged in health lawmaking [which] could, in theory, foster the development of a more effective, integrated and rational legal regime and, consequently, better collective management of global health concerns."[144] The WHO could "serve as a coordinator, catalyst, and, where appropriate, platform for important international health agreements."[145]

The idea that the WHO should seek to provide leadership in international health law making—or norm making more broadly—is an appealing one for those concerned about coherence in global health governance, but the realities are exceedingly complex, both within the WHO and in its inter-institutional relationships. Particularly difficult challenges arise in the trade and health context. Part IV explained trade's dominance of the trade–health governance relationship. In contrast to the institutional framework within which the WHO operates, the WTO regime embodies a wide range of "hard" legal obligations backed up by a compulsory dispute settlement system.

As noted earlier, WTO legal norms are developed not only by the Ministerial Conference and the General Council but also by the panels and the Appellate Body. While a panel has the ability to "seek information and technical advice from any individual or body which it deems appropriate,"[146] "seek information from any relevant source,"[147] and "consult experts to obtain their opinion on certain aspects of the matter"[148]—and both GATT[149] and WTO panels[150] have

142. Taylor, *supra* note 54, at 504.
143. *Id.*
144. *Id.* at 505.
145. *Id.* at 507. *See also* Gostin, *supra* note 56, at 996.
146. DSU, *supra* note 69, art. 13.1.
147. *Id*. art. 13.2.
148. *Id.*
149. *See, e.g.*, Report of the Panel, *Thailand–Restrictions on Importation of and Internal Taxes on Cigarettes*, paras. 50–56, DS10/R (Nov. 7, 1990), GATT B.I.S.D. (37th Supp.) at 200, at 216–18 (1991), *available at* http://www.wto.org/english/tratop_E/dispu_e/90cigart.pdf. "In *Thailand Cigarettes*, the Panel rather

received information from the WHO—panels remain independent and make their own decisions. While the WHO can provide information, this information does not carry any special weight, however important the WHO—and the global health community it represents—might consider the outcome of a dispute for global health.

While the WHO has been criticized for not engaging more robustly in trade and health issues,[151] it has been far from inactive. The WHA and the Executive Board have addressed trade and health in various contexts, including the impacts of trade agreements on access to drugs, particularly with respect to HIV/AIDS, health and intellectual property rights more broadly, the relationship of trade agreements to international migration of health personnel, negotiations to revise the IHR, and aspects of the FCTC.[152] In 2000, the WHO established a small programme on globalisation, trade, and health, which has been evolving since and is now part of its trade, foreign policy, diplomacy, and health programme.[153] In 2006, the WHA adopted a resolution on international trade and health,[154] which urged the WHO's member states to implement a range of measures designed to improve domestic "trade and health" capacity and enhance coherence; the resolution also requested the Secretariat, through the Director–General, to provide support to member states on "trade and health," build capacity, and "continue collaborating with the competent international organizations in order to support policy coherence

awkwardly consulted the WHO in order to access scientific expertise, which it then disregarded." Atik, *supra* note 4, at 599.

150. Panel Report, *European Communities–Measures Affecting the Approval and Marketing of Biotech Products*, paras. 4.137, 4.140, WT/DS291/R, WT/DS292/R, WT/DS293/R (Sept. 29, 2006), *available at* http://www.wto.org/english/tratop_e/dispu_e/cases_e/ds291_e.htm.

151. Gostin, *supra* note 56, at 996–97.

152. WHO, Exec. Bd., 116th Sess., Geneva, Switz., May 26–27, 2005, *International Trade and Health*: *Report by the Secretariat*, EB116/4, para. 1 (Apr. 28, 2005) [hereinafter WHO, *International Trade and Health*]. *See also* Margaret Bomba, *Exploring Legal Frameworks to Mitigate the Negative Effects of International Health-Worker Migration*, 89 B. U. L. REV. 1103, 1124–33 (2009).

153. Lee, Sridhar & Patel, *supra* note 71, at 419. *See also* Taylor, *supra* note 54, at 505. For the programme's website, see World Health Organization, Trade, Foreign Policy, Diplomacy and Health, http://www.who.int/trade/en/ (last visited Mar. 16, 2010).

154. WHA International Trade and Health Resolution, Res. WHA59.26, WHA59/2006/REC/1 (May 27, 2006) [hereinafter WHA International Trade and Health Resolution], *available at* http://apps.who.int/gb/ebwha/pdf_files/WHA59/A59_R26-en.pdf.

between trade and health sectors at regional and global levels, including generating and sharing evidence on the relationship between trade and health . . . ."[155] The resolution was adopted:

> Recognizing the demand for information on the possible implications of international trade and trade agreements for health and health policy at national, regional and global levels;
>
> Mindful of the need for all relevant ministries, including those of health, trade, commerce, finance and foreign affairs, to work together constructively in order to ensure that the interests of trade and health are appropriately balanced and coordinated . . . .[156]

In respect of the intersection between intellectual property rights and access to medicines, since 1996, the WHO has closely monitored the implementation of TRIPs and advised member states on ways of using TRIPS' "flexibilities" to allow them to achieve health goals.[157] In 2004, it established, pursuant to a 2003 WHA Resolution,[158] the WHO Commission on Intellectual Property Rights, Innovation, and Public Health (IPRIPH), which reported to the WHA in 2006.[159] Having considered the IRPIPH Commission's report, the WHA requested the convening of an Intergovernmental Working Group (IGWG) to develop a global strategy and plan of action in order to provide a medium-term framework based on the Commission's recommendations.[160] The IGWG completed its work in 2008, when the WHA adopted the *Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property*.[161] The WHO now has a Secretariat on Public Health, Innovation, and Intellectual Property (PHI), which focuses on implementation of the global strategy.[162]

155. *Id.*
156. *Id.*
157. Helfer, *supra* note 48, at 42.
158. *See* WHA Intellectual Property Rights, Innovation and Public Health Resolution, Res. WHA56.27, A56/VR/10 (May 28, 2003).
159. WHO, Comm'n on Intell. Prop. Rts., Innovation and Pub. Health, *Public Health Innovation and Intellectual Property Rights: Report of the Commission on Intellectual Property Rights, Innovation and Public Health* (2006) [hereinafter IPRIPH Report], *available at* http://www.who.int/intellectualproperty/report/en/index.html.
160. *See* Res. WHA59.24, A59VR/9 (May 27, 2006).
161. *See* Res. WHA61.21, A61/VR/8 (May 24, 2008).
162. *See* WHO, About PHI, http://www.who.int/phi/about/en/ (last visited Mar. 17, 2010).

The WHO has described its trade and health work as consisting of three main functions: performing analysis and research to better inform policy decisions, negotiations, dispute settlement, and agenda setting; creating tools and training materials to build capacity in member states; and meeting country requests for support in specific trade and health issues, either through country missions or regional or interregional workshops.[163] The WHO has produced a range of materials on trade and health issues, which are available either on its website or upon request.[164] It has collaborated with the WTO Secretariat, including by producing a 2002 joint study on *WTO Agreements and Public Health*[165] and developing and conducting training courses on multilateral agreements and public health.[166] It has been granted observer status at the WTO Committee on Sanitary and Phytosanitary Measures and the Committee on Technical Barriers to Trade, and ad hoc observer status in the Council for Trade in Services, the Council for Trade-Related Aspects of Intellectual Property Rights, and the Council for Trade in Services, Special Sessions.[167] It is currently collaborating with the WTO, the World Bank, the World Intellectual Property Organization (WIPO), the United Nations Conference on Trade and Development (UNCTAD), international experts, and trade and health policy makers from ten countries to develop a "diagnostic tool and companion workbook" in trade and health that will guide national policymakers in developing national policies and strategies related to trade and health and structuring their requests for capacity building on issues related to trade and health.[168] As noted above, the WHO has also provided information to GATT and WTO panels.

163. WHO, *International Trade and Health*, *supra* note 152, para. 10.

164. *See* WHO, Trade and Health, http://www.who.int/trade/resource/tradewp/en/index.html (last visited Mar. 17, 2010).

165. *See* WHO and WTO Secretariat, *WTO Agreements and Public Health: A Joint Study by the WHO and the WTO Secretariat* (2002), *available at* http://www.wto.org/english/rese/bookspe/whowtoe.pdf.

166. WHO, *International Trade and Health*, *supra* note 152, para. 14.

167. *See* WTO, International Intergovernmental Organizations Granted Observer Status to WTO Bodies, http://www.wto.org/english/thewto_e/igo_obs_e.htm (last visited Mar. 17, 2010).

168. *See* WHO, Trade and Health—Trade, Foreign Policy, Diplomacy and Health, http://www.who.int/trade/resource/tradewp/en/index.html (last visited Mar. 17, 2010). *See also* Richard D. Smith, Kelley Lee & Nick Drager, *Trade and Health: An Agenda for Action*, 373 LANCET 768, 772 (2009).

C. *The WHO as a Standard Setter*

One area in which the WHO has performed a role in respect of the governance of the trade and health relationship and in which some public health scholars and advocates argue that it should be more proactive is in the development of international standards. Derek Yach and Robert Beaglehole write of the "increasing need to establish global norms in a wide range of spheres to balance the otherwise unrestrained influences of powerful policy actors."[169] To do so, they argue, "public health capacities in trade and political science must be strengthened so as to effectively participate in the WTO where health issues are increasingly considered and to develop stronger WHO-led norms that could be used as the basis for resolving trade disputes in relation to products with health impacts."[170] Magnusson sees international standards on diet and nutrition, for example, as having "a positive impact on global health by serving to 'WTO proof' domestic and regional responses to chronic disease."[171] Baumberg and Anderson note the calls for a legally binding international Framework Convention on Alcohol Policy, either modelled on the FCTC or using an alternate approach, and argue that "[t]his would not automatically make WTO-inconsistent policies somehow permissible, but it would provide an international community of support for such policies, and potentially help to manage the relationship between alcohol and trade. It may also add weight to the defence of such policies under trade disputes . . . ."[172]

The notion that the WHO should develop standards to assist in managing the trade and health relationship makes substantial institutional sense. As Magnussson points out, the WTO "is neither a scientific nor a health agency and it does not develop standards."[173] But there are many different kinds of international standards and many different ways in which international standards may be relevant to the governance of trade and health, and the role that WHO can or should play will vary with these different kinds of standards.

The most direct way in which WHO-developed standards can have

169. Yach & Beaglehole, *supra* note 39, at 228.
170. *Id.* (citations omitted).
171. Magnusson, *Rethinking Global Health Challenges*, *supra* note 31, at 270.
172. Baumberg & Anderson, *supra* note 31, at 1956 (citations omitted).
173. Magnusson, *Non-communicable Diseases and Global Health Governance*, *supra* note 31, at 7 (citation omitted).

an impact on trade and health governance is through their effect under the TBT and SPS Agreements. Under Article 2.4 of the TBT Agreement, WTO members are required to use any relevant international standards "as a basis for their technical regulations" unless such standards would be "an ineffective or inappropriate means for the fulfilment of the legitimate objectives pursued . . . ."[174] Under Article 2.5, whenever a technical regulation applied for a legitimate objective is "in accordance with relevant international standards, it shall be rebuttably presumed not to create an unnecessary obstacle to international trade."[175]

Under Article 3.1 of the SPS Agreement, subject to certain exceptions, in order to "[h]armonize sanitary and phytosanitary measures on as wide a basis as possible, . . ." WTO members are required to "base their sanitary or phytosanitary measures on international standards, guidelines or recommendations, where they exist . . . ."[176] Under Article 3.2, measures which "conform to international standards, guidelines or recommendations . . . [are] deemed to be necessary to protect human, animal or plant life or health, and presumed to be consistent with the relevant provisions . . ."[177] of the SPS Agreement and the GATT. Annex A of the SPS Agreement identifies the Codex Alimentarius Commission, a body established and administered jointly by the FAO and the WHO, as the recognized international standard setter for food safety.[178] Atik writes that as a practical matter this means that such measures enjoy "substantial immunity" from challenge before the WTO dispute settlement system.[179]

However, beyond these two examples, in which international standards have an explicit role in the application of the WTO agreements, the precise purpose and effect of international standards developed by or through the WHO are much less clear. There may be dangers in entering too far into territory likely to be marked by some of the less desirable features of fragmentation.

174. TBT Agreement, *supra* note 86, art. 2.4.
175. *Id.* art. 2.5.
176. SPS Agreement, *supra* note 87, art. 3.1.
177. *Id.* art. 3.2.
178. *Id.* Annex A, para. 3(a).
179. Atik, *supra* note 4, at 602.

D. *Health Agreements to "Counterbalance" the Effects of WTO Agreements?*

The FCTC is the first treaty negotiated under the auspices of the WHO. The FCTC's Foreword records that it was "developed in response to the globalization of the tobacco epidemic," an epidemic "facilitated through a variety of complex factors with cross-border effects, including trade liberalization and direct foreign investment. Other factors such as global marketing, transnational tobacco advertising, promotion and sponsorship, and the international movement of contraband and counterfeit cigarettes have also contributed to the explosive increase in tobacco use."[180] The framing of the FCTC, in significant part, as a response to trade liberalization is common in the literature.[181]

Writing in 2002, when the FCTC was still being negotiated, Jose Alvarez argued that the idea that a tobacco control treaty should be negotiated through the WHO could be seen as a proposal that "one international organization, the WHO, regulate tobacco at least in part because another, the WTO, has been altogether too successful in reducing barriers to the tobacco trade and has ignored the resulting negative externalities."[182] In 2005, after its adoption by the WHA, Maya Prabhu and Sumudu Ataputtu wrote that the "FCTC represents the first time that the WHO has exercised its considerable treaty-making powers in the name of public health, *as an explicit counterbalance to another international legal regime*."[183] They described the FCTC as:

> a response to the World Trade Organization's (WTO) very success in reducing barriers to the international tobacco trade, at the expense of significant health externalities. Thus, the FCTC marks a new chapter in the health vs. trade debates,

180. WHO, *WHO Framework Convention on Tobacco Control*, at v (2003), *available at* http://whqlibdoc.who.int/publications/2003/9241591013.pdf.

181. *See, e.g.*, Allyn L. Taylor & Douglas Bettcher, *WHO Framework Convention on Tobacco Control: A Global "Good" for Public Health*, 78 BULL. WORLD HEALTH ORG. 920, 924–25 (2000). *See also* McGrady, *Trade and Tobacco Control*, *supra* note 31.

182. Jose E. Alvarez, *'The WTO as Linkage Machine'*, 96 AM. J. INT'L. L. 146, 149 (2002).

183. Maya Prabhu & Sumudu Atapattu, *The WHO Framework Convention on Tobacco Control: When the WHO Meets the WTO*, *in* SUSTAINABLE JUSTICE: RECONCILING ECONOMIC, SOCIAL AND ENVIRONMENTAL LAW 365, 366 (Marie-Claire Cordonier Segger & C. G. Weeramantry eds., 2005) (emphasis added).

> debates which the authors believe are more likely to be amplified in the future.[184]

This idea of establishing health treaties to "counterbalance" the effect of WTO agreements appears to have taken root. Labonte and Sanger argue that the FCTC "has raised the possibility of creating other health specific conventions outside of the ambit of WTO or other trade treaties" and that "[b]y promoting conventions such as these national governments can strengthen the international legal and institutional basis for collaboration to promote health, and *provide a counterbalance to international trade treaties*."[185] In an exploration of possible international arrangements to address the harms caused by alcohol, Room argues that the "strongest argument" against adopting a nonbinding instrument "may be the competitive force of binding conventions or treaties which intersect with the subject-matter under consideration."[186] The "existence and development of trade and free market agreements globally (under the World Trade Organization), regionally and bilaterally" is a "major consideration" with respect to psychoactive substances which are also trade commodities, such as tobacco, alcohol, and medications.[187] Room continues: "Trade dispute adjudications and negotiations have constrained the abilities of national and sub-national governments to restrict the alcohol market, and further such restrictions are under consideration. A binding public health-orientated agreement on alcohol is needed *as a means of countering these developments*."[188]

This notion that legally binding agreements should be developed in one multilateral institution explicitly to counterbalance the effects of legally binding agreements developed through another represents a manifestation of what Laurence Helfer has described as "regime shifting"—"an attempt to alter the status quo ante by moving treaty negotiations, lawmaking initiatives, or standard setting activities from one international venue to another."[189] Regime shifting provides an opportunity to generate "counterregime norms," either binding treaty rules or nonbinding soft law standards that "seek to alter the

184. *Id.*
185. Labonte & Sanger, *supra* note 106, at 742 (emphasis added).
186. Room, *supra* note 31, at 586.
187. *Id.*
188. *Id.* at 589 (emphasis added) (citations omitted).
189. Helfer, *supra* note 48, at 14 (citation omitted).

prevailing legal landscape."[190] Not surprisingly, both states and NGOs seek out the forum most likely to deliver their desired policy outcomes, basing their ultimate choices on such factors as differences in state membership and influence, law-making methods, mechanisms for monitoring and dispute settlement, institutional cultures, and permeability to outside influence.[191] They will often deliberately seek to create "strategic inconsistency"[192] "to force change by explicitly crafting rules in one elemental regime that are incompatible with those in another."[193] This can then "set the agenda" for future efforts, with diplomats operating in a legalized setting uncomfortable with "the existence of a glaring inconsistency across regimes . . ." and looking for ways to "restore rule alignment."[194] While the pursuit of a "counterbalancing" effect or the creation of strategic inconsistency can be unsettling for lawyers—the "drive for consistency" being "a hallmark of legalization"[195]—it is not without both political and policy merit. It can be used to generate positive policy outcomes that could not be achieved through working only in the initial forum. Nevertheless, its effectiveness in practice can be difficult to predict and when used as a counter to WTO treaties, it raises particular challenges.

First, it is not clear what effect legally binding agreements of the kind proposed, negotiated, and adopted through the WHO (or another body) would have on WTO obligations (and WTO panel and Appellate Body decisions). Of course, it ultimately depends what the content of such agreements is, how they deal with potential conflicts, and who their parties end up being. However, unless such agreements included specific conflicts clauses under which they would prevail over WTO agreements in the event of conflict *and* all WTO members became parties to such agreements—conditions rather unlikely to come into effect—significant uncertainty would remain.

With respect to the former condition, the story of the negotiation of the FCTC is perhaps instructive. Taylor describes "the relationship

190. *Id.*

191. *Id. See also* Kal Raustiala, *Density and Conflict in International Intellectual Property Law*, 40 U.C. DAVIS L. REV. 1021, 1027 (2007).

192. Kal Raustiala & David G. Victor, *The Regime Complex for Plant Genetic Resources*, 58 INT'L ORG. 277, 301 (2004).

193. *Id.* at 301–02.

194. *Id.*

195. *Id.* at 300.

between trade law and the FCTC" as "a keenly contested issue" throughout the negotiations.[196] The contest was between the positions that the FCTC should take precedence over trade obligations in the event of conflict and that the FCTC should be developed and applied in a manner consistent with existing international trade law.[197] The contest was ultimately resolved on the final day of the sixth and final negotiating session, with the inclusion in the preamble of the words "Determined to give priority to their right to protect public health"[198] but with the treaty remaining silent on conflicts between the FCTC and agreements, such as the WTO Agreements, concluded earlier in time, allowing Article 30 of the Vienna Convention on the Law of Treaties[199] to apply in the event of any conflict between the FCTC and any WTO agreements.[200]

While no two sets of negotiations are identical, either in their political and institutional context or their treatment of major substantive questions, the FCTC experience suggests that it should not be assumed that other health agreements negotiated through the WHO (or another body) would include a conflicts clause of the kind that was not agreed to in the tobacco context. It is arguable that the case for priority to tobacco control measures over trade obligations is a stronger one than for alcohol or unhealthy foods, for example, given the scale of harm caused by tobacco and the fact that, unlike these other products, it is inherently harmful and has no safe level of use.

With respect to the latter condition, the WTO has 153 members.[201] It is unlikely that *all* would become parties to these other proposed agreements—certainly not unless their content was largely uncontroversial and accordingly rather "weak." This is significant

196. Allyn L. Taylor, *Trade, Human Rights and the WHO Framework Convention on Tobacco Control: Just What the Doctor Ordered?*, *in* HUMAN RIGHTS AND INTERNATIONAL TRADE 322, 326 (Thomas Cottier, Joost Pauwelyn & Elisabeth Bürgi eds., 2005).

197. *Id.* at 326–28.

198. WHO FCTC, *supra* note 79, pmbl.

199. Vienna Convention on the Law of Treaties art. 30, May 23, 1969, 1155 U.N.T.S. 331, 8 I.L.M. 679, *available at* http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf.

200. Taylor, *supra* note 196, at 326–28.

201. *See* WTO, Understanding the WTO: The Organization—Member and Observers, http://www.wto.org/english/thewto_e/whatis_e/tif_e/org6_e.htm (last visited Mar. 17, 2010).

because the obligations contained in such agreements—including any effects on WTO obligations—would not apply to states that did not become parties to them.[202] Further, the extent to which WTO panels can take account *at all* of non-WTO obligations that are not held by all WTO members is a highly contested question.[203]

Thus, even between states that were both WTO members and parties to the health agreements, the effects of the health agreements on trade obligations would likely be uncertain. The legal effects on obligations owed to WTO members that did not become parties to such health agreements would likely be minimal at best.

This is not to say that legally binding norms agreed to through the WHO (or another forum) would have *no effec*t on WTO obligations. It is likely that—at least if widely ratified—they would have significant political impact, increasing the political threshold for bringing trade challenges with respect to matters covered by such norms. They might also be used by panels, whether explicitly or *sub silentio*, for example, in consideration of the necessity of health measures, including, perhaps, in assessing the importance of interests at stake or in demonstrating that certain measures are better regarded as complementary than alternative.

Nevertheless, there is a legitimate concern that negotiation and adoption of agreements in one institution, such as the WHO, in order to "counterbalance" the effects of WTO agreements, *at least without also attempting to build substantial linkages between the two institutions (and other relevant institutions) with respect to the subject matter of the proposed agreements*, could be a recipe for

202. *See* Werner Meng, *Conflicting Rules in the WHO FCTC and Their Impact*, *in* HUMAN RIGHTS AND INTERNATIONAL TRADE 334, 335 (Thomas Cottier, Joost Pauwelyn & Elisabeth Bürgi eds., 2005).

203. *See, e.g.*, F. Baetens, *Muddling the Waters of Treaty Interpretation? Relevant Rules of International Law in the MOX Plant OSPAR Arbitration and* EC - Biotech *Case*, 77 NORDIC J. INT'L L.197 (2008); JOOST PAUWELYN, CONFLICT OF NORMS IN PUBLIC INTERNATIONAL LAW: HOW WTO LAW RELATES TO OTHER RULES OF INTERNATIONAL LAW (2003); Joost Pauwelyn, *Bridging Fragmentation and Unity: International Law as a Universe of Inter-Connected Islands*, 25 MICH. J. INT'L L. 903 (2004); David Palmeter & Petros C Mavoridis, *The WTO Legal System: Sources of Law*, 92 AM. J. INT'L L. 398 (1998); Gabrielle Marceau, *WTO Dispute Settlement and Human Rights*, 13 EURO. J. INT'L L. 753 (2002); Benn McGrady, *Fragmentation of International Law or "Systemic Integration" of Treaty Regimes: EC-Biotech Products and the Proper Interpretation of Article 31(3)(c) of the Vienna Convention on the Law of Treaties*, 42 J. WORLD TRADE 589 (2008).

trouble—including poorly conceived law, significant uncertainty for both states and the institutions involved, inefficiency in the use of resources, and difficulties in implementation.

It should be pointed out that, of course, the WHO and WTO are institutions composed of and governed by states. There is substantial overlap between the WHO's 193 members[204] and WTO's 153 members. Thus a counterbalancing strategy does not simply potentially set two international institutions against one another. It also potentially creates cleavage between different government departments within the same state. This is likely to be more of a problem in some states than others, depending on their capacity to manage such governance challenges. Fidler notes that even highly developed countries with significant governance capacities have had struggles in dealing with globalized problems, and "[m]any developing and least-developed countries do not . . . have the governance capacity to address adequately globalized problems."[205]

E. *The Need for Inter-Institutional Processes*

The most obvious response to the challenges and opportunities of fragmentation is of course better and principled coordination between those institutions whose mandates either overlap or complement one another (or both). Cottier, Pauwelyn, and Bürgi observe that, "[w]hile institutions may be set up differently and operate side-by-side, real-life problems do not respect jurisdictional boundaries, and law-making in different institutions inherently spills over into other regulatory fields."[206] Law making "needs to entail mutual information and interaction between different fora and organizations."[207] This is not only to avoid conflict but also to allow "norm-creating organizations to draw from each other's unique competencies and mandates in order to deliver a better end-product to the international community."[208] Such inter-institutional cooperation is most likely to be effective when it conforms to emerging principles of global administrative law that seek to safeguard transparent, reasoned, and

204. World Health Organization, *Countries* (2010), http://www.who.int/countries/en (last visited Mar. 17, 2010).
205. Fidler, *supra* note 15, at 302.
206. Cottier, Pauwelyn & Bürgi, *supra* note 53, at 8.
207. *Id.*
208. Mosoti, *supra* note 42, at 173.

legitimate regulatory and administrative decision making.[209]

In the final article of the *Lancet* series, Smith, Lee, and Drager set out "an agenda for action."[210] The authors make a number of suggestions for achieving greater coherence between trade and health, with action recommended at both the domestic and international levels to strengthen evidence on trade and health links; build trade and health engagement and capacity; and assert health goals in trade policy.[211] They make recommendations for action by a range of entities including the WHO, the WTO, the World Bank, the International Monetary Fund (IMF), national governments, NGOs and civil society, foundations, and academics.[212] If adopted, their recommendations would assist in effecting the kind of inter-sectoral dialogue, learning, and decision making that forms the essential foundation of coherent policy making and implementation.

Building on these recommendations, this Article focuses on action that might be taken to build more effective institutional linkages between the two key international agencies in the field, the WHO and the WTO. It is axiomatic that effective cooperation between these two organizations is essential to coherence at the international level (as well as at the domestic level). It is critical to recognize that the WHO can only do so much on its own. If trade dominates the trade–health relationship by virtue of the relative legal and political strength of the WTO regime as compared to that of the WHO and the fragmented regime of global health governance more broadly and health does poorly as a result of that dominance, it seems clear that the problem cannot be adequately addressed without action both involving and within the WTO, through which the value of health and an understanding of its determinants becomes more deeply internalized within the WTO system.

F. *Exploring Some Possibilities*

Some possible approaches are suggested here for further exploration. The aim of the suggested arrangements is to facilitate the kind of inter-institutional discussion, development of mutual understanding, and cooperation needed to maximize the benefits and

209. *See generally* Mitchell & Sheargold, *supra* note 27.
210. Smith, Lee & Drager, *supra* note 168.
211. *Id.* at 769–72.
212. *Id.*

minimize the risks of fragmentation.[213]

1. A Formal Relationship Should Be Established Between the WHO and the WTO

The WTO has signed cooperation agreements with the IMF, the World Bank, WIPO,[214] and the Office International des Epizooties (OIE)[215] and a memorandum of understanding with UNCTAD.[216] The IMF and the World Bank have observer status in WTO bodies as provided for in their Agreements with the WTO, whereas, as noted above, the WHO has observer status in only two committees (the Committee on Sanitary and Phytosanitary Measures and the Committee on Technical Barriers to Trade) and ad hoc observer status in only three committees (the Council for Trade in Services, Council for Trade-related Aspects of Intellectual Property Rights, and the Council for Trade in Services, Special Sessions).[217] The WHO has entered into agreements with the International Labour Organization (ILO),[218] FAO,[219] UNESCO,[220] the International Atomic Energy

213. This Article does not examine the possibility of amendments being made to any of the WTO Agreements or a radical change to global health governance involving a "hardening" of legal obligations, such as by agreement to new, more specific health-related legal obligations or the introduction of dispute settlement procedures that might rival those of the WTO. This is not to suggest that such developments could never occur but rather to explore some more incremental changes that might be made within existing arrangements. Other suggestions include the encouragement by the WTO of its members to ratify human rights treaties and the enforcement of such requirement through the use of trade sanctions and the dispute settlement system. *See generally* Phillip Countryman, *International Trade and World Health Policy: Helping People Reach their Full Potential*, 21 PACE INT'L L. REV. 241, 273–78 (2009).

214. TRIPS Agreement: WTO-WIPO Cooperation Agreement, Dec. 22, 2005, *available at* http://www.wto.org/english/tratop_e/TRIPs_e/wtowip_e.htm.

215. *See* WHO Agreement with the *Office International des Epizooties*, Res. WHA57.7, A57/DIV/5 (May 22, 2004) [hereinafter WHO-OIE Agreement].

216. Steve A. Charnowitz, *A New WTO Paradigm for Trade and the Environment*, 11 SINGAPORE Y.B. OF INT'L L. 15, 29 (2007) (citation omitted).

217. WTO, About the Organization—International Intergovernmental Organizations Granted Observer Status to WTO Bodies, http://www.wto.org/english/thewto_e/igo_obs_e.htm (last visited Mar. 17, 2010).

218. Agreement Between the International Labour Organization and the World Health Organization, July 10, 1948, 19 U.N.T.S. 270 [hereinafter ILO-WHO Agreement].

219. Agreement Between the Food and Agriculture Organization and the World Health Organization, Dec. 13, 1948, 76 U.N.T.S. 172 [hereinafter FAO-WHO Agreement].

220. Agreement Between the United Nations Educational, Scientific and Cultural Organization and the World Health Organization, July 17, 1948, 44

Agency (IAEA),[221] the United Nations Industrial Development Organization (UNIDO),[222] the International Fund for Agricultural Development (IFAD),[223] the Universal Postal Union (UPU),[224] and the OIE.[225]

A formal cooperation agreement would be useful both as a symbol of mutual recognition of the importance of the relationship between the two bodies—and between trade and health—and as providing a formal framework for ongoing discussions of linked issues and development, implementation, and monitoring of joint activities.[226] Such an agreement could, for example, allow for exchanges of personnel between the two organizations,[227] a proactive step to build relationships and deepen understanding.

2. Joint Committees of Members of the Two Bodies Should Be Established on Specific Trade and Health Issues, such as on Trade and Noncommunicable Diseases

Formal fora for discussion between states and sub-state regulatory actors, administered and technically supported by the Secretariats of the two organizations, should enable exploration of issues from both trade and health perspectives, the seeking of common ground, and significant learning for states and the two institutions. Issues to be addressed by the committees could be identified by the WHA as the governing body of the specialized agency responsible for

U.N.T.S. 324.

221. Agreement Between the International Atomic Energy Agency and the World Health Organization, May 28, 1959, 339 U.N.T.S. 388.

222. Agreement Between the World Health Organization and the United Nations Industrial Development Organization, May 19, 1989, 1549 U.N.T.S. 403 [hereinafter UNIDO-WHO Agreement].

223. WHO, *Resolution of the 33rd World Health Assembly: Agreement between the International Fund for Agricultural Development and the World Health Organization*, WHA33.21 (May 23, 1980).

224. WHO, *Resolution of the 52nd World Health Assembly: Agreement between the World Health Organization and the Universal Postal Union*, WHA52.6 (May 24, 1999).

225. WHO-OIE Agreement, *supra* note 215.

226. *See* Lee, Sridhar & Patel, *supra* note 71, at 420.

227. WHO's agreements with the ILO (art. V), the FAO (art VII), and UNESCO (art. VI) allow for "interchange of personnel on a temporary or permanent basis, in appropriate cases, in order to obtain the maximum benefit from their services." In the agreement between the WHO and UNIDO (art. 8), the two organizations "agree to co-operate in order to facilitate the interchange of staff and to promote efficiency and effective co-ordination on their respective activities."

international health (at which the WTO has observer status).[228] Reports of such committees could be provided to the WTO General Council and the WHA through the Director–Generals of the two organizations.[229]

3. Joint Inter-Secretariat Committees Should Be Established Between the WTO and the WHO on Specific Trade and Health Issues, Again such as Trade and Noncommunicable Diseases

Matters to be addressed by such committees could be agreed to by the Director–Generals of the two organizations. The purpose would be similar to that of joint committees of member states, though work done by the secretariats should be deeper, more technical, and carried out in a less overtly political context. Regular reports on the work of such committees could be provided to the joint committees of members of the two bodies recommended above to enhance the transparency and legitimacy of the activity. The work of inter-secretariat committees could assist in the identification of priority issues for reference to joint committees of states and facilitate the effective working of such committees once established.[230]

4. A Committee on Trade and Health Should Be Established Within the WTO, with the WHO Having Observer Status and Being Encouraged to Actively Participate in its Work

The establishment of such a committee would signal the importance to be attached to health by the WTO and provide a forum

228. WTO, Work with other International Organizations, http://www.wto.org/english/thewto_e/coher_e/coher_e.htm (last visited Mar. 17, 2010).

229. WHO's agreements with the ILO (art. III), the FAO (art. III) and UNESCO (art. IV), and UNIDO (art. 6) allow for the establishment of joint Committees to which "any question of common interest" may be referred. ILO-WHO Agreement, *supra* note 218, art. III; FAO-WHO Agreement, *supra* note 219, art. III; UNESCO-WHO Agreement, *supra* note 201, art. IV; UNIDO-WHO Agreement, *supra* note 222, art. 6.

230. The WHO's agreement with FAO (art. VI) provides for establishment by agreement of "inter-secretariat committees to facilitate co-operation in connexion with specific programmes of work or projected activities with which the two organizations may be mutually concerned." The WHO's agreement with the IAEA (art. V) provides for the establishment of joint committees of secretariats to be convened "when appropriate to consider questions of substantive interest to both parties."

within the WTO for discussion of health issues by states.[231] Such WTO committees exist with respect to the environment and development, established by the Ministerial Conference.[232] Alternatively, such a committee (or committees) could be established with respect to particular issues of trade and health, perhaps after request by the WHA.

5. Inter-Agency Task Forces on Specific "Trade and Health" Issues of Concern Should Be Established, Including the WHO, the WTO and Other Relevant Agencies

There is currently a United Nations Ad Hoc Interagency Task Force on Tobacco Control, which is chaired by the WHO and comprises seventeen agencies of the United Nations system and two organizations outside the UN system, including the WTO.[233] The UN Secretary General provides a report to the Economic and Social Council every two years on progress made by the Task Force.[234] One possibility worth exploring would be broadening the mandate of the Task Force to deal with noncommunicable diseases more broadly, not only tobacco control. There would likely be substantial learning through consideration of the similarities and differences among various noncommunicable diseases, their risk factors, and strategies for addressing them. To be effective, the Task Force should meet regularly, and annual reports rather than biennial reports should be prepared.

For each of these proposals, the active participation of representatives of civil society should be provided for, enhancing the

231. Fidler suggests such a committee or working group and notes that it could provide "a catalyst for broadening and deepening domestic attempts to integrate trade and health policies." Fidler, *supra* note 15, at 317.

232. WTO–The Committee on Trade and Environment, http://www.wto.org/english/tratop_e/envir_e/wrk_ committee_e.htm (last visited Feb. 22, 2010); WTO–The Committee on Trade and Development, http://www.wto.org/english/tratop_e/devel_e/d3ctte_e.htm (last visited Feb. 22, 2010). Charnowitz writes of the Committee on Trade and the Environment that although it has not reached any significant decisions, it may be having some positive impact, in serving as a continuing forum on international trade and the environment. Charnowitz, *supra* note 217, at 28.

233. WHO, United Nations Ad Hoc Interagency Task Force on Tobacco Control, http://www.who.int/tobacco/global_interaction/un_taskforce/en/ (last visited Mar. 17, 2010).

234. *Id.*

transparency and legitimacy of the work being performed as well as its quality.

The idea behind these proposals is not only to facilitate dialogue and understanding, though these would be valuable outcomes in themselves. It would be hoped that the suggested processes would ultimately lead to the development of norms and institutional practices that better integrated legitimate health objectives into trade policy making[235] and implementation, and legitimate trade objectives into health policy making and implementation. Conflicts between trade and health cannot be avoided, but they can surely be better managed.

It is not suggested that it would be easy to achieve all or even any of the above proposals. Questions of political will, resources, and governance arrangements would of course arise. It should also be acknowledged that, for those whose primary interest is in the promotion and protection of health, the proposals carry risks. They could lead to changes in the dynamic within the WHO, bringing more "trade people" into its work, potentially diluting its health focus and weakening the norms that it develops, at least from a health perspective. They may also affect the organizational culture within the WHO. For example, the WHO is generally regarded as more open and more inclusive of nongovernmental organizations than the WTO.[236] This possibility of inter-institutional influence with respect to norms of process, manifested in either formal rules or less formal institutional practices, should be carefully examined.

VI. CONCLUSION

As last year's *Lancet* series on trade and health demonstrates, there are genuine problems in the governance of trade and health, both at the international and domestic levels. As this Article has argued, these are examples of much wider global governance stresses, which

235. For example, declarations on "trade and health" matters could be made by the Ministerial Council or interpretations issued by the Ministerial Council or the General Council under Article IX:2 of the Marrakesh Agreement. GATT Annex 1A, *supra* note 5, art. IX:2.

236. For a discussion of the culture of the WTO, see, for example, Mosoti, *supra* note 42, at 175; Daniel C. Esty, *Good Governance at the World Trade Organization: Building a Foundation of Administrative Law*, 10 J. INT'L ECON. L. 509 (2007); Steger, *supra* note 114, at 140–41; Edith Brown Weiss, *Trade, Investment and the Environment: Closed Boxes?*, 100 AM. SOC'Y INT'L L. PROC. 25, 25–26 (2006).

create fundamental challenges for both the WTO and the WHO, as they do for other institutions.

This Article offers some suggestions for more structured inter-institutional cooperation between the WTO and the WHO. It argues that discussion by trade and health policy makers, academics, and advocates of the suggested possibilities for cooperation would be a fruitful exercise for both trade and health.

Ultimately, questions of inter-institutional arrangements between agencies with different mandates, values, and cultures are complex practical, political, and strategic ones[237] that need to be carefully worked through. There are no perfect solutions, but there are opportunities to make a difference for the better.

237. *See* John H. Jackson, *Afterword: The Linkage Problem – Comments on Five Texts*, 96 AM. J. INT'L L. 118, 122 (2002) ("To flesh out the details of a landscape for making these power allocation decisions requires elaborate analysis and no-nonsense empirical studies, weighing not only the apparent or relevant needs for cooperation at an institutional level involving participation by many nations, but also the caliber and character of the available international institutions that might be used. Does a particular institution have the resources or effective participants, or fulfill the important democratic legitimacy criteria, or have the means to achieve cooperation between the players so as to be effective both in working towards its goals and in preserving or enhancing other important goals (such as reducing disputes, treating all kinds of societies fairly, enhancing the appropriate efficiency of markets, and granting national societies "margins of appreciation?").