Berkeley Journal of International Law

Volume 31 | Issue 2 Article 5

2013

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Recommended Citation

Estalyn Marquis, *Review of Trade and Public Health: The WTO, Tobacco, Alcohol, and Diet by Benn McGrady*, 31 Berkeley J. Int'l Law. 472 (2013).
Available at: http://scholarship.law.berkeley.edu/bjil/vol31/iss2/5

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Review of *Trade and Public Health: The WTO, Tobacco, Alcohol, and Diet* by Benn McGrady

By
Estalyn Marquis*

In an effort to address the alarming rise of obesity in New York City, Mayor Michael Bloomberg recently initiated a citywide rule that limits the size of sodas and sugary drinks sold in restaurants and other venues to sixteen ounces or less.[1] Within months and amidst vehement backlash, the American soft-drink industry, joined by several business and restaurant groups, brought suit in an attempt to overturn the regulations.[2] Bloomberg argued that the restrictions are necessary in a city where more than half of the residents are obese or overweight. The soda industry and its allies counter that the rules are discriminatory and lead to unfair advantages for competitors not subject to the restrictions.[3] At a moment in history when Americans are sharply divided on how to balance public health concerns with concerns about freedom of choice and competition, *Trade and Public Health* offers a timely and global perspective on the complicated intersection of international trade and public health.

During the codification of many major trade agreements, including the General Agreement on Tariffs and Trade (GATT) of 1947, the field of public health was primarily concerned with infectious disease.[4] This was the case even as recently as 1994, when GATT was incorporated into the World Trade Organization (WTO) Agreement.[5] In recent years, however, the public health field has grown increasingly concerned with addressing noncommunicable

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1. Michael M. Grynbaum, *Health Panel Approves Restrictions on Sale of Large Sugary Drinks*, N.Y. TIMES, Sept. 13, 2012.

2. Michael M. Grynbaum, *Soda Industry Sues to Stop a Sales Ban on Big Drinks*, N.Y. TIMES, Oct. 12, 2012.

3. Michael M. Grynbaum, *In NAACP, Industry Gets Ally Against Soda Ban*, N.Y. TIMES, Jan. 23, 2013.

4. BENN MCGRADY, TRADE AND PUBLIC HEALTH: THE WTO, TOBACCO, ALCOHOL, AND DIET 2 (2011).

5. *Id.*

Published by Berkeley Law Scholarship Repository, 2013

diseases associated with tobacco consumption, alcohol consumption, and an unhealthy diet. In a widespread study of developing nations, public health researchers recently predicted that by the year 2030, tobacco consumption will cause ten million deaths annually.[6] Alcohol consumption is estimated to cause 3.8 percent of deaths globally.[7] Inadequate fruit and vegetable intake alone causes approximately 2.7 million deaths annually from conditions like gastrointestinal cancer, ischemic heart disease, and stroke.[8] As the harmful effects of alcohol, tobacco, and poor diet continue to rise, developing countries are particularly susceptible to noncommunicable disease as a result of weak healthcare systems.

It is against this backdrop of pressing global concerns about noncommunicable diseases that Dr. Benn McGrady crafts a careful analysis of the World Trade Organization's law and its effects on domestic attempts to address tobacco consumption, alcohol use, and poor diet. McGrady's credentials and extensive experience leave him well qualified to take on such a crucial and complicated topic. Originally from Australia, McGrady is Director of the O'Neill Institute Initiative on Trade, Investment, and Health at Georgetown University Law Center, where he earned his L.L.M. and is now a professor. McGrady also holds a doctorate from Monash University in Melbourne. In addition to advising public health bodies, foreign governments, and intergovernmental organizations, McGrady has particular experience advising on the implications of international trade and investment agreements on domestic public health measures and on legal issues concerning the World Health Organization (WHO) Framework Convention on Tobacco Control.

This study grew out of the author's experience in a variety of academic, professional, and geographical settings. McGrady began research on the implications of WTO law for tobacco control while he was a research assistant at the VicHealth Centre for Tobacco Control, The Cancer Council Victoria in Melbourne. McGrady then began his PhD on the same subject. While a PhD candidate, he spent significant time conducting research and living in Bangkok. McGrady then went on to expand his thesis at Georgetown University Law Center, where in addition to his role as Adjunct Professor, he was Research Assistant Professor at the Department of International Health, School of Nursing and Health Studies.[9]

Given McGrady's multi-faceted background, he could have approached *Trade and Public Health* from a number of angles, including a public health or policy angle. In the end, however, he opted to craft an explicitly legal study of the intersection of trade and public health, with an aim to help public health lawyers and trade lawyers bridge the gaps between their fields. Indeed, the

6. *Id.* at 14.
7. *Id*. at 16.
8. *Id.* at 17.
9. *Id.* at xiv.

analytical focus of the book reflects the author's experience as an active advisor to organizations working on public health issues on the international level. Thus, the study is focused on the types of issues that arise in the context of public health lawmaking at both the international and domestic levels.[10]

The overarching goal of McGrady's study is to explore "whether domestic regulatory autonomy maintained by the WTO-covered agreements reflects an appropriate balance between the protection of public health and the interests underlying the WTO agreement."[11] In other words, are WTO member states able to effectively craft public health interventions while maintaining their international trade obligations? McGrady sets out to examine this question through the lens of interventions to prevent noncommunicable diseases associated with tobacco, alcohol, and diet.

McGrady's analysis begins with a fascinating look into the ways that the liberalization of international trade in tobacco, alcohol, and food has contributed to the increasing pervasiveness of noncommunicable diseases globally. For instance, McGrady noted several studies that support the idea that cigarette consumption increases significantly in countries as they become more open to trade and see decreasing cigarette prices as a result.[12] This phenomenon, also observed in the context of alcohol consumption and poor diet, illustrates the theoretical tension between trade liberalization and measures to reduce the consumption of potentially harmful goods.[13] McGrady notes a second key tension in concerns about regulatory economy. To highlight how this tension plays out in practice, the author explores tobacco-control advocates' arguments that trade agreement limits on nontariff barriers to trade have restricted domestic regulatory freedom to such a degree that successful tobacco control is essentially prohibited.[14] This may lead to "regulatory chill," whereby WTO Members may hesitate to (or simply decide not to) employ lawful public health measures out of a fear of violating the WTO agreement.[15]

The first chapter of *Trade and Public Health* establishes a framework for McGrady's analysis and identifies two key factors in the relationship between trade and public health. The first factor is determinacy—the ability of WTO Members to determine whether health measures are lawful. McGrady deftly illustrates this first factor with real world cases, such as member countries' attempts to control tobacco packaging and to limit misleading descriptions like "light" and "mild." The tobacco lobby has traditionally been successful in its attempts to prevent measures to control its products by reference to trade agreements like the North American Free Trade Agreement (NAFTA) and the

10. *Id.*
11. *Id.* at 277.
12. *Id*. at 3.
13. *Id.*
14. *Id*. at 7.
15. *Id*. at 14.

Agreement on Technical Barriers to Trade (TBT Agreement).[16] McGrady concludes that confusion regarding the lawfulness of public health measures may lead to inaction, especially in those countries with relatively weak capacity in the field of trade law.[17]

The second factor McGrady identifies is the way in which WTO law balances the trade objectives of the WTO Agreement against the need to protect public health. A balance between trade and health, McGrady argues, would require that prohibitions and obligations of WTO-covered agreements are not interpreted in an overly broad manner. Moreover, although his focus is on domestic regulatory autonomy, McGrady argues that a balanced relationship between trade and public health would require attention to the ways in which international trade instruments interact with international health instruments. In other words, health and trade instruments would each provide guidance on norms to the other, thereby creating more coherence and limiting the problems that occur when conflicts arise between treaties.[18] McGrady's unique framework for exploring the intersection of trade and public health is a compelling one, allowing for in-depth analysis of WTO law and public health in the following chapters.

Before examining the role of international trade treaties with regard to specific noncommunicable diseases, the author first explores the broader treatment of public health instruments within the context of the WTO. Chapter 2 of *Trade and Public Health* examines how WTO law takes health instruments into account in the context of dispute settlement. McGrady's analysis suggests that WTO panels have been willing to consider extraneous public health instruments even without any reference to a rule explicitly allowing them to do so. International health instruments might be used to interpret the scope of WTO norms or to allow health interests to be integrated with WTO law. Although the dominant view is that WTO panels should not apply extraneous treaties, McGrady notes that health instruments might still be utilized as tools for the effective interpretation of international norms. For example, in *Dominican Republic—Import and Sale of Cigarettes*, the WTO panel looked to the WHO Framework Convention on Tobacco Control (FCTC) in its assessment of the utility of tax stamps for the prevention of tax evasion before turning to the specific dispute at issue.[19]

At the same time, it is unlikely that WTO panels would take kindly to the idea of a mandatory rule requiring a panel to take an extraneous health treaty into account when deciding on a dispute. For an illustration of this resistance, McGrady turns to the decision of the panel in *EC—Approval and Marketing of*

16. *Id.*

17. *Id*. at 23.

18. *Id*. at 29.

19. Vienna Convention on the Law of Treaties, art. 31(3)(c), May 23, 1969, 1155 U.N.T.S. 331.

Biotech Products. Article 31(3)(c) of the Vienna Convention on the Law of Treaties states that in the process of treaty interpretation, "there shall be taken into account, together with the context . . . any relevant rules of international law applicable in the relations between the parties."[20] The language in the provision might be interpreted to support a broad consideration of health treaties in the context of WTO dispute resolution. The WTO panel in *EC—Approval and Marketing of Biotech Products*, however, held a more restrictive view that Article 31(3)(c) is only triggered when all parties to a treaty under interpretation by a panel are also parties to the extraneous treaty in question.[21] McGrady notes that the restrictive view held by the WTO panel in *EC—Approval and Marketing of Biotech Products* has the potential to isolate WTO law from other international law and is most likely not the correct interpretation of Article 31(3)(c). Returning to *Trade and Public Health*'s focus on a balance between the objectives of trade law and public health concerns, McGrady explains that the WTO panel's restrictive interpretation of Article 31(3)(c) suggests that WTO law is not sufficiently open to normative integration. In other words, a normative imbalance between trade and health still persists.

In the next chapter, *Trade and Public Health* examines the application and effect of WTO-covered agreements on strategies that member states might use to further public health goals: differential tax measures, subsidies, price floors, and restrictions on advertising and marketing. Perhaps not surprisingly, given McGrady's analysis in the previous chapter, there is still confusion among member states about which types of public health measures may violate WTO-covered agreements and which types may be acceptable. McGrady skillfully demonstrates how this confusion might develop.

For instance, while specific laws that levy the same amount of tax on tobacco or alcohol products by volume is unlikely to result in a violation of the General Agreement on Tariffs and Trade (GATT), there is a greater chance that differential taxes will result in a violation.[22] The entire purpose of differential taxes is to alter the competition between goods depending on the relative health risks that they pose to consumers.[23] As a result, there is always at least some chance that this type of tax may alter the conditions of competition between imported and domestic goods to the advantage of domestic producers, even if this was not the intention of the measure. What is fascinating and somewhat troubling is that the regulatory legitimacy of a measure is not likely to determine whether or not a violation of GATT has occurred. Rather, the sole focus is on the extent to which the goods in question are in competition with each other.[24] Although recent case law suggests that the legitimacy of a regulatory measure

20. MCGRADY, *supra* note 4, at 45.
21. *Id*. at 46.
22. *Id*. at 279.
23. *Id.*
24. *Id.*

may once again be relevant to determining when a violation has occurred, unpredictability is still a problem for member states. As McGrady argues, member states, especially developing countries, are "limited in their capacity to combat unpredictability" in the application of WTO rules.[25]

Another intriguing aspect of McGrady's analysis in Chapter 3 focuses on the use of tariffs and subsidies. The use of tariffs may be an enticing public health measure when a tariff does not simply encourage domestic production of relatively unhealthy goods. For an island state that does not have the ability to produce relatively unhealthy goods in sufficient quantities, for example, a tariff on harmful goods may be a very useful public health measure, since other forms of taxation could be viewed as protective of domestic production. In the dietary context, subsidies might be utilized in the form of a direct welfare transfer to the consumer. For instance, the U.S. "food stamp" scheme can be tailored to ensure that healthful foods are subsidized.[26]

Countries might also choose to utilize agricultural production subsidies to bolster food security and adequate nutrition.[27] In the case of both subsidies and tariffs, however, it is crucial to note that WTO Members are limited not by legal rules, but by power politics in the realm of international negotiations on market access.[28] Thus, although tariffs and subsidies may prove useful tools in promoting public health goals in the context of some WTO member states, these options may be simply unavailable depending on a specific member state's established autonomy and bargaining power. This means that some WTO member states will have greater access to the tools of tariffs and subsidies than others.[29] Given the analysis of measures to promote public health goals in Chapter 3, McGrady makes a compelling argument that WTO Members may implement a public health measure in good faith, yet nevertheless end up violating prohibitions in a WTO-covered agreement.

Having established a clear framework for understanding the intersection of international trade and public health, the author then delves into a more detailed analysis of the "necessity test" and specific international instruments. Chapters 4 and 5 of *Trade and Public Health* examine how exceptions may preserve regulatory autonomy in the context of a violation of WTO-covered agreements, as well as the specific impact of the Sanitary and Phytosanitary (SPS) and the TBT agreements on measures to regulate products.

The "necessity test," which originates in Article XX(b) of the GATT, states that nothing in the agreement shall prevent the enforcement by any contracting party of measures necessary to protect human, animal, or plant life or health—as long as such measures do not constitute arbitrary or unjustifiable discrimination

25. *Id.*
26. *Id*. at 103.
27. *Id.*
28. *Id*. at 102.
29. *Id*. at 281.

between countries.[30] Recent case law, such as the WTO panel's decision in *Brazil—Retreaded Tyres*, suggests that a narrowly constructed regulatory goal could enhance the possibility of a country's measure being found lawful when such a measure would have otherwise violated a WTO-covered agreement.[31] While this suggests a high degree of judicial deference to narrowly tailored regulatory goals, McGrady argues that application of the "necessity test" remains somewhat unpredictable. In the dietary context especially, a long chain of causation between a regulatory measure and the prevention of a noncommunicable disease like obesity could suggest that a measure is not, in fact, necessary.[32] The reality, however, that a panel may evaluate the necessity of a regulatory measure in qualitative, rather than solely in quantitative terms, may increase the likelihood of a regulatory measure being found lawful.

McGrady finds that exceptions like Article XX(b) of the GATT do contemplate a reasonable balance between protecting market-access commitments and preserving the regulatory autonomy of member states, despite concerns about predictability.[33] In the specific context of the SPS and TBT agreements, however, McGrady finds that the new provisions of these agreements, in combination with a lack of case law, leads to uncertainty about how their provisions might be interpreted and how these agreements might ultimately balance trade and public health.

Reflecting on the complexities and conclusions of the first five chapters, *Trade and Public Health*'s final chapter considers possible areas of law reform and then goes on to form overall conclusions about the intersection of trade and public health. Although other possible areas of reform are considered, McGrady seems to find the concept of "harmonization" most compelling. He points to recent developments in balancing regulatory autonomy with trade goals in order to reform international instruments to better support the goals of the Global Strategy Diet. Further, McGrady argues that developing guidelines for tobacco product regulation and further standardization in the alcohol context could accomplish the important task of reducing uncertainty for members, while concurrently promoting regulatory harmonization.[34]

Ultimately, McGrady concludes that a large amount of indeterminacy still exists within any analysis of trade and public health. Given the open-textured nature of many provisions of WTO law and the consequently wide margin of discretion given to WTO panels, it is simply difficult to determine how many issues related to public health regulatory measures might be resolved. At the same time, this indeterminacy affects any attempt to analyze the balance

30. General Agreement on Tariffs and Trade (GATT), Oct. 30, 1947, Art. XX(b), 61 Stat. A-11, 55 U.N.T.S. 194.

31. MCGRADY, *supra* note 4, at 283.

32. *Id.*

33. *Id*. at 284.

34. *Id*. at 287.

between trade interests and public health. For instance, under GATT Article XX(b), case law is well developed, so it is easier to identify balance between competing interests. Under the SPS and TBT agreements, however, the case law is not well developed, and it is therefore difficult to predict outcomes. Despite this uncertainty, McGrady optimistically notes that the Appellate Body of the WTO has shown sensitivity to public health objectives in recent decisions, while simultaneously recognizing the challenge of maintaining this sensitivity as member states continue to address the growing issue of noncommunicable disease.

As McGrady's conclusion suggests, the task of balancing trade interests and public health concerns will only grow more complicated over time. *Trade and Public Health* represents a valuable contribution to an area of the legal field that has received relatively little attention, especially given the enormity of its impact on so many daily lives. In establishing his book as a legal analysis, McGrady chose not to focus on institutional interaction or policy prescriptions. Nevertheless, following McGrady's detailed analysis of WTO law and its potential impact on regulatory autonomy, readers might very well be left desiring some discussion of how the balance (or imbalance) of trade and public health impacts stake holders and policy makers at the national and international level. Given McGrady's experience advising organizations on public health issues, a case study on a specific country's efforts to enforce health regulations would have been particularly enlightening without unreasonably broadening the scope of the study. In a similar vein, readers might also desire stronger and clearer recommendations from McGrady on how the relationship between trade objectives and public health concerns might become more balanced.

Ultimately, *Trade and Public Health* brought to life a complicated legal reality that is often obscured for even the most powerful international and domestic players. It achieved its ambitious goal of clarifying the complex and multi-faceted legal issues at the intersection of WTO law and public health. The study undoubtedly will prove useful to legal practitioners in the fields of international health or trade and to anyone who wants to understand the intersection of trade and health in more depth. Mayor Bloomberg—and leaders with similar public health goals—will certainly want to pick up a copy.[35]

35. As of this writing, Mayor Bloomberg's ban on sugary drinks was struck down by a New York state judge, who called the limits "arbitrary and capricious." Bloomberg has vowed to appeal the decision, claiming that he does have the legal authority to enact a law related to such an important public health issue. Michael M. Grynbaum, Judge Blocks New York City's Limits on Big Sugary Drinks, N.Y. TIMES, Mar. 11, 2013.