

Glossary on free trade agreements and health part 1: the shift from multilateralism and the rise of 'WTO-Plus' provisions

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ABSTRACT

The global trading system has undergone a shift away from multilateral trade negotiations to a 'spaghetti-bowl' of regional and bilateral free trade agreements (FTAs). In this two-part glossary, we discuss why this shift has occurred, focusing on how it poses new challenges for public health. Specifically, we introduce key terms that shape this new trading environment and explain them through a public health lens. Part 1 of this glossary focuses on provisions in FTAs that build on previous agreements of the World Trade Organization (WTO). These provisions are commonly designated as 'WTO-Plus'. This approach continues into part 2 of the glossary, which also considers components of FTAs that have no precedent within WTO treaties. Following a broader discussion of how the current political context and the COVID-19 pandemic shape the contemporary trade environment, part 2 considers the main areas of trade and health policy incoherence as well as recommendations to address them.

INTRODUCTION

International trade and the intergovernmental rules (trade and investment agreements) governing it have been pressing policy concerns for most of the world's countries for the past half century. They have also attracted the attention of public health since at least the dawn of the World Trade Organization (WTO) in 1995. A previous two-part glossary in this journal outlined the history between trade and its known or potential health consequences up until the early 2000s, focusing largely on the multilateral trading system of the WTO and its Doha Development Round, initiated in 2001.^{1,2} Beginning in the 1990s, the global trading system has undergone a shift away from multilateral trade negotiations to what is now described as a 'spaghetti-bowl' of regional and bilateral free trade agreements (FTAs), also referred to internationally as preferential trade agreements. In this update to the original glossary, we discuss why this shift occurred, focusing on how contemporary FTAs pose new challenges for public health. Specifically, we introduce key terms that shape this new trading environment and explain them through a public health lens.

After a brief background on the rise of regional/bilateral FTAs, part 1 of this glossary introduces

new trade obligations that figure prominently in current and recent trade negotiations. We focus first on those provisions that build on previous WTO agreements. This approach continues into part 2 of the glossary, which also considers components of FTAs that have no precedent within WTO treaties, such as provisions related to regulatory coherence, labour standards and environmental standards. Following a broader discussion of how the current political context and the COVID-19 pandemic shape the contemporary trade environment, part 2 considers the main areas of trade and health policy incoherence as well as recommendations to address them.

THE RISE OF REGIONAL AND BILATERAL FTAS

FTAs are reciprocal agreements between two or more countries that exist alongside the WTO multilateral trading system. Countries that join FTAs agree to obligations that offer more liberalised trade in goods and services, stronger intellectual property rights, new foreign investor protections, and more constraints on trade-related policies than those currently available under WTO rules. These provisions, by definition many of which are 'WTO-Plus', apply only to those countries that join and ratify these FTAs, giving them trade or investment preferences not available to other WTO members. FTAs are not only allowed under the WTO system, they are encouraged as a means of members taking seriously the commitment to further liberalise trade among themselves. As of January 2020, there are 303 FTAs in force. [Figure 1](#) demonstrates the rise in FTAs over time.

The rise in FTAs began in the early 1990s and is closely aligned with the signing of the Single European Act, which in turn spurred the start of negotiations of the North American Free Trade Agreement (NAFTA) between the USA, Mexico and Canada. This is theorised to have spawned a 'domino effect' for other countries in the Americas and Europe to also pursue agreements outside of the multilateral system.³ Uncertainty and doubt surrounding stalled trade talks in the General Agreement on Tariffs and Trade (GATT) beginning in the 1990s, and later with the WTO and its 2001 Doha Development Agenda, also incentivised moves towards alternatives to multilateral negotiations.⁴ Contemporary events, such as the election of Donald Trump, provide further momentum for the proliferation of FTAs (as discussed in part 2 of the glossary).



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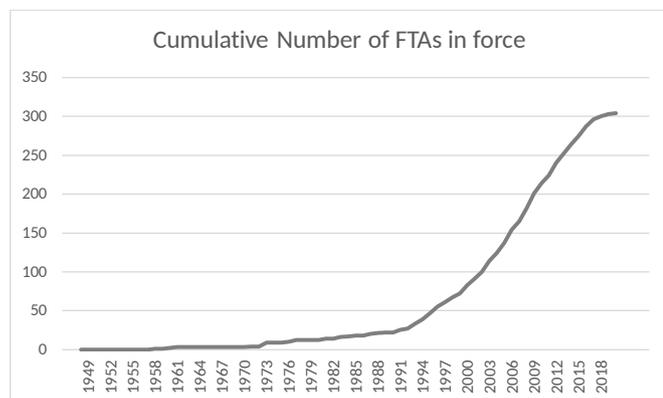


Figure 1 Cumulative number of free trade agreements (FTAs) in force. This figure does not include preferential FTAs, which are non-reciprocal agreements between two or more countries. Source: Authors from WTO, Regional Trade Agreements Information System.

Public health studies continue to assess the various ways in which these new agreements can profoundly impact the health of populations.^{5–13} In the following discussion, our focus is on the specific type of language that is institutionalised in FTAs. We use this approach in order to better aid public health practitioners

and policy makers in the analysis of the potential health implications of future FTAs.

PUBLIC HEALTH IMPLICATIONS OF FTAS

WTO-Plus provisions

FTAs import many of their provisions from existing WTO agreements, but also introduce new elements that often (1) expand liberalisation commitments and intellectual property protections and (2) include new rules governing the design and implementation of public health measures. These revised provisions, known as WTO-Plus provisions, not only increase the complexity of rules governing international trade, they can also create new health risks, increase the set of options for foreign investors to challenge governments' health measures, and decrease the policy space available to governments to address public health concerns.

We discuss WTO-Plus language that has figured prominently in current and recent trade negotiations and its potential impact on health (see [table 1](#) for a brief description of the largest and most important contemporary FTAs). We first focus on two key trade-related areas with the most direct health policy implications (sanitary and phytosanitary measures (SPS) and technical barriers to trade (TBT)), before turning to the expansion of the investor rights regime and the evolution of dispute settlement

Table 1 Overview of major contemporary free trade agreements (FTAs)

FTA	Key notes
United States-Mexico-Canada Agreement (USMCA)	An FTA between Canada, Mexico and the USA, agreed in October 2018 and ratified by each country, with the final ratification (Canada) occurring in March 2020. The USMCA represents a renegotiation of NAFTA and incorporates many of the provisions in the CPTPP from which the USA withdrew. In December 2019, a 'Protocol of Amendment' to the Agreement was made, involving four key and contentious areas: pharmaceuticals, labour, environment and dispute resolution. The USMCA eliminates ISDS between the USA and Canada, and significantly narrows its scope between the USA and Mexico.
Comprehensive and Progressive Agreement for Trans-Pacific Partnership (CPTPP)	An FTA between Australia, Brunei, Canada, Chile, Japan, Malaysia, Mexico, New Zealand, Peru, Singapore and Vietnam. The CPTPP evolved from the Trans-Pacific Partnership (TPP). The TPP was the first 'mega-regional' FTA, originally accounting for over 40% of the global economy, before the USA withdrew in 2017. The CPTPP then suspended several controversial USA-driven rules governing pharmaceuticals, and has been signed and ratified by seven countries at the time of writing. It came into force for the first group of ratifying countries in December 2018. The Trump administration has indicated a potential for the USA to rejoin the Agreement, if it is amended to reflect 'America First' interests. Several other Pacific Rim nations have also indicated a desire to join.
Comprehensive Economic and Trade Agreement (CETA)	An FTA between Canada and the European Union (EU), signed on 30 October 2016 and approved by the European Parliament on 15 February 2017. The Agreement is still subject to ratification by the EU and national legislatures, but most provisions are provisionally in force, including rules on intellectual property rights (IPR) that exceed the requirements of the WTO Agreement on Trade-Related Intellectual Property Rights (TRIPS), referred to as TRIPS-plus rules. It is widely regarded as the template for an eventual USA/EU Transatlantic Trade and Investment Partnership agreement, negotiations on which have been on hold since 2017.
Regional Comprehensive Economic Partnership (RCEP)	Under negotiation since 2012 and signed in November 2020, this FTA in the Asia-Pacific Region first involved 16 countries, including the Association of Southeast Asian Nations (ASEAN) members and the 6 countries that have existing trade agreements with ASEAN (Australia, China, India, Japan, Republic of Korea and New Zealand). India opted out of RCEP in November 2019. This FTA is often portrayed as competition to the more American-centric original TPP, and was intended to reflect the diverse needs of its member states, which include a significant number of lower-income and middle-income countries. More recently, the RCEP has reportedly grown to more closely resemble the CPTPP.
Pacific Agreement on Closer Economic Relations (PACER) Plus	This FTA was finalised in 2017 by Australia, New Zealand and 12 Pacific Island countries after almost 8 years of negotiations. Papua New Guinea and Fiji, the two largest Pacific Island economies, were initially involved but withdrew from negotiations prior to their conclusion. The economic position of the small island states, which have little to export and are heavily reliant on tariffs and development assistance as sources of government revenue, stands in contrast to the two high-income countries involved in the agreement (Australia and New Zealand), which provide aid to these smaller states and also host the headquarters of businesses seeking access to their markets. Australia, New Zealand and Samoa have so far ratified the agreement. Five more countries are needed to meet the required minimum of eight signatory countries for the agreement to come into force.
Trade in Services Agreement (TiSA)	A proposed FTA covering trade in services (such as banking, healthcare and transport), currently involving 50 mostly high-income or middle-income countries. Negotiations were initiated in 2013 by a handful of countries responsible for over half of all global services trade (primarily the USA, the EU and Australia), which were unhappy with lack of progress under WTO GATS. Leaked drafts show that the now-stalled TiSA is a complex agreement that applies to all sectors except those which governments explicitly exclude, and multiple annexes, all intended to create an ambitious treaty that could pose risks to public services, especially if governments decide to rescind privatisation experiments that prove to be too costly or inequitable.

Adapted from Gleeson and Labonte.²⁰

CPTPP, Comprehensive and Progressive Agreement for Trans-Pacific Partnership; GATS, General Agreement on Trade in Services; ISDS, investor-state dispute settlement; NAFTA, North American Free Trade Agreement; WTO, World Trade Organization.

Box 1 Potential public health measures subject to challenge

- ▶ Alcohol labelling measures.
- ▶ Food and beverage nutrition labelling measures.
- ▶ Measures to restrict or lower pesticide residues.
- ▶ Measures to limit animal growth hormones.
- ▶ Import bans for public health measures, for example, asbestos imports or turkey tail imports.
- ▶ Bans on fossil fuels or revoking fossil fuel permits.
- ▶ Nationalising private health services.

mechanisms. Although falling outside the health policy focus of this glossary, we note that reductions in tariffs (ie, border taxes) on goods also have direct and indirect implications for health in the form of (1) increased diversity and volume, as well as reduced costs, of health-promoting or health-harmful products^{14 15}; (2) employment shifts¹⁶; and (3) foregone public revenue in many low-income countries.¹⁷ FTAs are also associated with changes in global value chains, which, too, can have important implications for health,¹⁸ but this discussion also falls outside of the health policy scope of this paper. While we provide a brief background on the original WTO provisions in this discussion, readers are encouraged to refer to Labonté and Sanger's^{1 2} glossary for a more indepth discussion of the specific WTO agreements and their respective health implications.

Sanitary and phytosanitary measures

The WTO Agreement on the application of SPS sets out rules for how governments can use public health measures to ensure food safety and control plant or animal carried diseases. Examples of public health measures that can be impacted by the SPS Agreement include limits on pesticide residue in food, inspection of products for containments, and bans on animals or animal products from areas in which disease outbreak has occurred (see [Box 1](#)). In short, WTO SPS rules define the conditions under which public health measures in these areas can restrict trade without violating trade rules. WTO SPS text dictates that such public health measures should be consistent with international standards, specifically the Alimentarius Commission ('Codex').¹ Key to the WTO SPS Agreement is that public health measures with higher standards can be introduced if there is *scientific justification*. Historically, public health measures that exceed international standards could be introduced based on a minority of scientific opinion.¹⁹ This has been a pivotal component to the implementation of the precautionary principle which enables protective measures to be adopted when scientific evidence about a hazard is uncertain.^{2,20}

Language in the Comprehensive and Progressive Agreement for Trans-Pacific Partnership (CPTPP) and the more recent United States-Mexico-Canada Agreement (USMCA) is illustrative of the WTO-Plus SPS language in FTAs. In both agreements, SPS rules, like the original WTO SPS rules, stipulate conformity to international standards. However, if governments want to implement measures beyond international standards, both agreements seem to raise the bar for the burden of scientific evidence required to implement such measures (effectively ruling out the use of the precautionary principle).^{8 9} The CPTPP, for example, requires that such measures must be 'based on *documented and objective scientific evidence*' (CPTPP Art. 7.9, our emphasis).

Both the CPTPP and USMCA also introduce WTO-Plus language that makes it more cumbersome for governments

to implement new SPS-related public health regulations. The USMCA, for example, requires Parties to 'provide an explanation of the reasons and pertinent relevant information regarding the measure upon request' if another Party believes the new regulation may constrain its exports (Art. 9.6.14). It also calls on Parties 'to endeavor to enhance the compatibility of its sanitary and phytosanitary measures with [those] of the other Parties' up to and including identical measures (Art. 9.7.2). Taken together, these new WTO-Plus SPS stipulations signal the potential for regulatory chill², as governments may be unwilling to implement novel public health regulations with these policy impediments in mind.

Technical barriers to trade

The WTO TBT Agreement deals with technical regulations on goods undertaken for reasons of security, health or environmental protection.² It is particularly relevant to trade in unhealthy commodities such as tobacco, alcohol and unhealthy foods.²⁰ In these areas, TBT rules apply to public health measures like labelling requirements, conformity assessment procedures, and product standards. The two main requirements of the WTO TBT Agreement are that such regulations do not create 'unnecessary obstacles to international trade', and that if alternative measures exist, those that are 'less-trade restrictive' must be implemented.

Several concerns have been raised around the public health implications of TBT chapters in FTAs (see [Box 1](#)). While several FTAs have seemingly permissive language about the ability of countries to regulate in the interest of public health, they also include provisions that immediately limit this ability. The TBT chapter of the CPTPP, for example, stipulates that 'nothing in this Chapter shall prevent a Party from adopting or maintaining technical regulations or standards, *in accordance with its rights and obligations under this Agreement, the TBT Agreement and any other relevant international obligations*' (Art. 8.3, ¶15, our emphasis). In plain language, the italicised text means that countries can do whatever they like but only as long as it does not violate anything else in the FTA.

Like FTA SPS language, FTA language surrounding TBT rules imports the basic tenets of the WTO Agreement, defers to the Codex as an international standard setting body and adds more requirements that reduce governments' regulatory flexibilities. The USMCA is exemplar in this regard, requiring countries to 'cooperate with each other...to ensure that international standards, guides, and recommendations that are likely to become a basis for technical regulations...do not create unnecessary obstacles to international trade' (Art. 11.4.4). In practice, this means that health considerations in setting new public health measures, such as labelling requirements or product standards, will take a back seat to trade compliance.⁸ Under TBT language in the USMCA, the three North American countries are also required to consider all possible international standards in creating their own regulations and must provide a reason if there are some standards they do not consider. Here, the concern is that a government might accept an international standard with a lower level of safety than another providing greater protection.⁸ FTAs can also contain annexes which further reduce regulatory flexibilities in terms of specific sectors, such as cosmetics.⁸

Some TBT provisions in FTAs contain broader language in terms of the bodies that should be considered relevant in standard setting. A major public health concern here is that such language could also lead to the acceptance of increased corporate involvement in policy-making, simultaneously introducing

new delays in developing new regulations and standards.⁸ The CPTPP, for example, includes a provision that ‘Each Party shall allow persons of the other Parties to participate in the development of technical regulations, standards and conformity assessment procedures by its central government bodies...on terms no less favourable than those it accords to its own persons’ (Art. 8.7, ¶11). In the general definitions of the CPTPP, a person of a Party would include a multinational corporation (Art. 1.3).⁹ The USMCA goes one step further, requiring new public health measures to undergo impact assessments that allow for private corporate actors to directly petition a country’s regulatory authorities if they believe that there is a less trade restrictive alternative.⁸

Harmonisation of standard setting at a high level may be desirable. If it defers to corporate voluntary regulatory language, however, harmful commodities produced in a country with no labelling requirements might not be obligated to meet the labelling requirements of an importing country (for more on this risk in relation to nutrition see, eg, Thow *et al*¹¹). Furthermore, new requirements that parties to an agreement shall permit wine and spirits suppliers to indicate information on supplementary labels (such as in the CPTPP TBT annex) have raised concerns that this could be interpreted in ways that lead to weaker alcohol labelling rules.²¹ For example, a recent Food Standards Australia New Zealand background paper for new mandatory pregnancy warning labels on alcohol shows that the decision to not mandate front of pack labels was shaped by concerns that this ‘could contravene free trade agreements’.²²

Investor rights and dispute settlement

While the WTO is primarily dedicated to liberalising and governing trade relations, the General Agreement on Trade in Services (GATS) created pathways for countries to open their borders to greater foreign direct investment (FDI) in services. Known as mode 3 in GATS, governments commit to open broad sectors of their economy to foreign commercial presence, and to rules and restrictions governing FDI in that sector.² The WTO also provides a limited range of protections for foreign investors in the Agreement on Trade-Related Investment Measures (TRIMS), which seeks to eliminate trade distortive investment measures such as local content requirements or restrictions on the volume or value of imports enterprises may purchase.²

NAFTA was one of the first FTAs to incorporate the international investment system into the global trade system, as up to this point the two had operated largely independently. The first international investment agreement (IIA), for example, was a bilateral investment treaty (BIT) signed between Germany and Pakistan in 1959. BITs slowly increased during the 1980s, but only began to surge in numbers in the 1990s. As of early 2020, an astounding 2336 BITs are in force, and over 300 other treaties have investment provisions contained within them, such as FTAs like CPTPP and NAFTA.²³

IAs expand the rights provided by TRIMS, such as providing foreign investors with the right to national treatment and most favoured nation, as well as rights against the seizure of physical property by a government (direct expropriation) or against government measures that permanently destroy the value or use of the investment without fair compensation (indirect expropriation).¹ One of the most ambiguous provisions from a public health perspective has been the requirement that governments guarantee foreign investors a right to ‘fair and equitable treatment’. The interpretation of this right has varied widely, with dispute settlement tribunals sometimes having made rulings that

this obligation extends to the state ensuring the stability and predictability of the regulatory system.

The most controversial element of FTA investment rules is the investor–state dispute settlement (ISDS) regime. While members of the WTO are able to seek compliance through the terms of the WTO agreements, its dispute settlement mechanism is only open to states (although investors can lobby a member state to challenge another member state) and the goal is to have the respondent country bring its policies into line with its WTO obligations. States do not receive financial compensation but, if a dispute is ruled in their favour and the respondent country does not change its policies, they negotiate acceptable compensation, such as tariff reductions in the interest of the complaining member.²⁴ ISDS allows foreign private investors to directly bring forward claims against states for financial compensation. Unlike the WTO dispute mechanism which relies on a standing Dispute Settlement Body, and which is transparent in publishing its proceedings and is subject to an appeals mechanism¹, ISDS claims are arbitrated in secret by international tribunals. Tribunals are comprised of international investment lawyers, one chosen by the investor-claimant, another by the respondent government and a third mutually agreed on by the other two. Procedurally, ISDS has been criticised for a lack of transparency, little or no opportunity for public input into proceedings, conflicts of interest in tribunals, and little or no appeals processes.²⁰ Substantively, many of the provisions in IAs (especially those dating to the 1980s and 1990s) are broadly stated and open to varying interpretations by tribunals. To date, foreign investors have used the system to challenge a wide array of public policy measures, including measures on taxation, chemical and mining bans, environmental restrictions, transportation and disposal of hazardous waste, health insurance, tobacco control, the price and delivery of water, and regulations to improve the economic situation of minority populations.²⁵ Such challenges do not always win, neither do states, since even when they do prevail in a ruling they usually face defensive legal costs that are not always or fully reimbursed. ISDS claims are thus another source of regulatory chill as governments could find themselves being sued over actions taken in response to newly identified public health risks,^{26–28} or public health emergencies, such as the COVID-19 pandemic.^{29 30}

While integration of the two regimes is now common practice in FTAs, increasingly countries are implementing new safeguards for public policy. One notable case in public health was giving CPTPP member states the option to exclude tobacco measures from ISDS in the agreement. This compromise was largely due to public backlash from Philip Morris suing Australia through investment arbitration over tobacco plain packaging measures. Several CPTPP members also subsequently signed side letters with each other excluding or severely restricting use of ISDS rules.²⁰ Other agreements are similarly attempting to address the weaknesses of existing health protections originally imported from the WTO, such as the general exception, which permits members to adopt measures that violate trade provisions if they are ‘necessary to protect human health, animal or plant life or health’ and do not constitute a means of arbitrary or unjustifiable discrimination between countries, or a disguised restriction on trade.¹ To date, only one of 44 attempts to invoke this general exception has been successful in WTO dispute settlement, failing 18 times on the grounds that the defending state was unable to establish that measures were ‘necessary’ to protect health.³¹ Agreements such as the Peru-Australia Free Trade Agreement, signed in 2018 and entering into force in 2020, have revised such wording in the investment chapter to state that: ‘No claim may be brought under this Section [ISDS] in relation to a measure that is *designed and implemented* [our emphasis] to protect or promote public health’. Such a change should, in theory, lower the

burden of proof on defending states and increase the utility of this health protection.

PART 2 OF GLOSSARY

This concludes part 1 of our glossary. Part 2 will continue to focus on WTO-Plus provisions of FTAs, particularly in the areas of trade-related intellectual property rights, trade in services and government procurement. It will then move to discuss FTA provisions which have no precedent within WTO treaties, specifically those obligations related to regulatory coherence, labour standards and environmental standards. Part 2 also provides a broader discussion of how the current political context and the COVID-19 pandemic shape the contemporary trade environment, and concludes with a consideration of the main areas of trade and health policy incoherence and offers recommendations to address them.

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