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Intersections between Trade and Noncommunicable Disease

1. INTRODUCTION

The impact of the Marrakesh Agreement Establishing the World Trade Organization (WTO) (hereafter WTO Agreement)[1] – and its linkage to other social issues has long been a subject of debate.[2] One aspect of this debate is the linkage of trade and public health. In 2006 the World Health Assembly (WHA) passed a resolution stressing the need for greater coordination in the development of trade and health policies and 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."[3] Following this, in 2007, the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand issued the Oslo Ministerial Declaration. The declaration affirmed the interconnectedness of trade and health policies "in the formulation of all bilateral, regional and multilateral trade agreements."[4]

More recently, in early 2009, *The Lancet*, a leading public health journal, published a series of papers on trade and health. A number of commentators called for greater interaction between the public health and trade policy communities and for the public health community to play a greater role

[1] Marrakesh Agreement Establishing the World Trade Organization, April 15, 1994, The Legal Texts: The Results of the Uruguay Round of Multilateral Trade Negotiations 4 (1999), 33 I.L.M. 1144 (1994) [hereinafter WTO Agreement].

[2] See, for example, the "Symposium on the Boundaries of the WTO" in 96(1) *American Journal of International Law*,(January 2002).

[3] Fifty-Ninth World Health Assembly, International Trade and Health – 59/15 available at http://www.who.int/gb/ebwha/pdf_files/WHA59/A59_R26-en.pdf (visited 12/12/07).

[4] "Oslo Ministerial Declaration – Global Health: A Pressing Foreign Policy Issue of Our Time," 369 *The Lancet*, London, (2007), pp. 1371–1378.

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in trade policy making.[5] This series of papers was reflective of the trade and health issues that have garnered attention since the conclusion of the Uruguay Round, such as those relating to intellectual property rights and access to medicines[6] as well as trade in health services.[7] These issues have largely arisen by virtue of the post-1994 trade architecture and the conclusion of new agreements like the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the General Agreement on Trade in Services (GATS).

Although this focus on new agreements and their impact on health has merit, little attention has been given to the way that changes in public health practice have affected the relationship between trade and health. When the General Agreement on Tariffs and Trade (GATT) 1947 was agreed, the primary focus of public health practice was to address infectious disease. This was also the case in 1994 when the GATT was incorporated into the WTO Agreement. However, over recent years new conceptualizations of public health have expanded the field to encompass efforts to address noncommunicable diseases associated with risk factors such as tobacco consumption, alcohol consumption, and unhealthy diet.

There are at least two obvious points of tension between this new public health and the trade regime. The first is a theoretical tension between trade liberalization and measures to reduce the consumption of certain goods at the population level. The general benefits of liberal trade policies, such as greater competition and lower prices, can translate into negative health consequences. In particular, where increased competition and lower prices stimulate consumption of harmful products, there is likely to be a correlative increase in associated morbidity and mortality. This also has flow-on effects for health systems. Tariffs and subsidies affect the cost of goods, meaning that the use of these instruments can form an important part of the environment in which choices are made about consumption.

For example, a number of studies have offered empirical confirmation of the conclusion that trade liberalization may stimulate demand for tobacco

5 See, for example, David Fidler, Nick Drager, and Kelley Lee, "Managing the Pursuit of Health and Wealth: The Key Challenges," 373(9660) *The Lancet*, London, (Jan 24–30, 2009), pp. 325–331; Richard D. Smith, Kelley Lee, and Nick Drager, "Trade and Health 6: Trade and Health: An Agenda for Action," 373(9665) *The Lancet*, London, (Feb 28–Mar 6, 2009), pp. 768–773; Rhona MacDonald and Richard Horton, "Trade and Health: Time for the Health Sector to Get Involved," 373(9660) *The Lancet*, London, (Jan 24–30, 2009), pp. 273–274.

6 Richard Smith, Carlos Correa, and Cecilia Oh, "Trade and Health 5: Trade, TRIPS, and Pharmaceuticals," 363(9664) *The Lancet*, London, (Feb 21–27, 2009), pp. 684–691.

7 Richard Smith, Rupa Chanda, and Viroj Tangcharoensathien, "Trade and Health 4: Trade in Health-Related Services," 363(9663) *The Lancet*, London, (Feb 14–20, 2009), pp. 593–601.

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products. Frank Chaloupka and Adit Laixuthai[8] were the first to address the issue in an examination of the opening of tobacco markets in Japan, Taiwan, South Korea, and Thailand. Chaloupka and Laixuthai concluded that "cigarette consumption was nearly ten percent higher, on average, in 1991 in the four countries whose markets were opened to US cigarettes than it would have been if the markets had remained closed."[9] Similarly, Chee-Ruey Hsieh, Teh Wei Hu, and Chien Fu Jeff Lin[10] examined the impact of the opening of the Taiwanese market to U.S. cigarettes and concluded that "opening the market to cigarette imports led to a 20% increase in per capita cigarette consumption in 1987."[11]

A number of studies have also examined the relationship between general trade openness (using a share of trade in gross domestic product as a measure) and tobacco consumption.[12] In this respect, Craig Depken concluded that the "openness of a country to international trade … causes a decrease in the price of cigarettes."[13] Similarly, Allyn Taylor and others concluded that trade liberalization leads to increased smoking, particularly in low- and middle-income countries that have traditionally been less open.[14] Douglas Bettcher and others drew substantially the same conclusion.[15]

In addition, Bettcher and others found that "increased levels of [foreign direct investment] should lead to higher levels of cigarette consumption."[16]

[8] Frank Chaloupka and Adit Laixuthai, "U.S. Trade Policy and Cigarette Smoking in Asia," NBER Working Paper Series, Working Paper 5543, (April 1996) [hereinafter Chaloupka and Laixuthai, "U.S. Trade Policy"].

[9] Ibid., p. 15.

[10] Chee-Ruey Hsieh, Teh Wei Hu, and Chien Fu Jeff Lin, "The Demand for Cigarettes in Taiwan: Domestic Versus Imported Cigarettes," 17(2) *Contemporary Economic Policy*, (April 1999), pp. 223–234 [hereinafter Hseih, Hu, and Lin, "The Demand for Cigarettes in Taiwan"].

[11] Ibid., p. 231.

[12] Craig Depken, "The Effects of Advertising Restrictions on Cigarette Prices: Evidence from OECD Countries," 6 *Applied Economics Letters*, (1999), pp. 307–309 [hereinafter Depken, "Advertising Restrictions"]; Allyn Taylor, Frank Chaloupka, Emmanuel Guindon et al., "The Impact of Trade Liberalization on Tobacco Consumption" in Prabhat Jha and Frank Chaloupka (eds), *Tobacco Control in Developing Countries*, World Bank and World Health Organization, Oxford University Press, (2000), pp. 343–364 [hereinafter Jha and Chaloupka, *Tobacco Control in Developing Countries*]; Douglas Bettcher, Chitra Subramaniam, Emmanuel Guindon et al., "Confronting the Tobacco Epidemic in an era of Trade Liberalization," WHO Commission on Macroeconomics and Health, World Health Organization, (2001), CMH Working Paper Series, WG 4: 8 [hereinafter Bettcher et al., "Confronting the Tobacco Epidemic"].

[13] Depken, "Advertising Restrictions," p. 308.

[14] Taylor et al., "The Impact of Trade Liberalization on Tobacco Consumption," p. 360.

[15] Bettcher et al., "Confronting the Tobacco Epidemic," p. 51.

[16] Ibid., p. 52.

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This conclusion is consistent with the observations of Anna Gilmore and Martin McKee, who charted investment levels and tobacco production and consumption levels in former Soviet countries between 1991 and 2000.[17] Gilmore and McKee concluded that cigarette consumption increased almost exponentially in line with rapid increases in cigarette production, and that such increases in consumption were concentrated in countries receiving tobacco industry investment.[18] Increases in consumption of approximately 56 percent were recorded for countries that received major tobacco industry investment, whereas a 1 percent drop in consumption was recorded in those countries that did not receive any such investment.[19]

The authors of these studies offer theories of why tobacco consumption increased. Chaloupka and Laixuthai offered two "possible explanations."[20] One explanation was that increased competition led to price reductions that stimulated demand. Another explanation was that increases in advertising and promotion of U.S. cigarettes stimulated demand.[21] In addition to these factors, Bettcher and others considered potential explanations that include brand proliferation and the targeting of untapped market segments.[22] Both Taylor and others and Bettcher and others also make reference to differences in the quality of domestic and imported tobacco products as a potential motivator for trade,[23] the implication being that newly imported products may satisfy latent demand for higher-quality products. Gilmore and McKee drew similar conclusions, arguing that women and young people were targeted by the introduction of new brands in the former Soviet Union, and that consumption levels prior to 1990 may have been artificially low due to lack of supply.[24]

Although there is less empirical evidence of the relationship between trade liberalization and harmful use of alcohol,[25] it stands to reason that trade

[17] Anna Gilmore and Martin McKee, "Exploring the Impact of Foreign Direct Investment on Tobacco Consumption in the Former Soviet Union," 14 *Tobacco Control*, (2005), pp. 13–21 [hereinafter Gilmore and McKee, "Exploring the Impact"].
[18] Ibid., p. 18.
[19] Ibid., p. 19.
[20] Chaloupka and Laixuthai, "U.S. Trade Policy," p. 14.
[21] In this regard, Chaloupka and Laixuthai recognized that this conclusion was supported to some degree by anecdotal evidence and also by the Japanese study on advertising. A. Hagihara and Y. J. Takeshita, "Impact of American Cigarette Advertising on Imported Cigarette Consumption in Osaka, Japan," 4 *Tobacco Control*, (1995), pp. 239–244.
[22] Bettcher et al., "Confronting the Tobacco Epidemic," p. 49.
[23] Ibid.; Taylor et al., "The Impact of Trade Liberalization on Tobacco Consumption," p. 344.
[24] Gilmore and McKee, "Exploring the Impact," pp. 19–20.
[25] One example can be found in Meichum Kup, Jean-Luc Heeb, Gerhard Gmel et al., "Does Price Matter? The Effect of Decreased Price on Spirits Consumption in Switzerland," 27(4) *Alcoholism: Clinical and Experimental Research*, (2006), pp. 720–725.

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liberalization may have similar effects in the alcohol sector as in the tobacco sector. Lower prices may stimulate consumption,[26] and increases in marketing may have a similar effect.[27] Thus, to the extent that increases in consumption increase morbidity and mortality, liberalization in the alcohol sector may have negative effects on public health.[28]

It is also possible to observe a relationship between trade liberalization and increasing levels of obesity.[29] As Corinna Hawkes has argued, trade liberalization "affects the whole food supply chain by influencing the incentives farmers and agribusinesses have to produce different foods, food imports and exports (very directly), and food processing retailing and advertising, which have all been profoundly affected by the growth of global food companies."[30] More specifically, trade liberalization has facilitated a trend toward increased consumption of vegetable oils, meats, and highly processed foods, all of which are associated with a nutrition transition.[31] Some commentators attribute this to the role that freer trade has played in reducing the relative cost of dietary energy in a context in which energy-dense foods and diets cost relatively less than nutrient-dense foods and diets and in which consumption of energy-dense foods increases as income declines.[32]

[26] Alexander Wagenaar, Matthew Salois, and Kelli Komro, "Effects of Beverage Alcohol Price and Tax Levels on Drinking: A Meta-Analysis of 1003 Estimates from 112 Studies," 104 *Addiction*, (2009), pp. 179–190; see contra Jon Nelson, "Alcohol Advertising Bans, Consumptions and Control Policies in Seventeen OECD Countries, 1975–2000," *Applied Economics*, (2008), pp. 1–21.

[27] Peter Anderson, Avalon de Bruijn, Kathryn Angus et al., "Impact of Alcohol Advertising and Media Exposure on Adolescent Alcohol Use: A Systematic Review of Longitudinal Studies," 44(3) *Alcohol & Alcoholism*, (2009), pp. 229–343.

[28] Some support for this proposition can be found in a resolution of the WHO Regional Committee for South-East Asia SEA/RC59/R8 Alcohol Consumption Control – Policy Options, in which the committee notes that "certain trade agreements … facilitate the free flow of and investment in alcohol, which boosts the consumption and negative impact of alcohol in the region."

[29] See generally Chantal Blouin, Mickey Chopra, and Rolph van der Hoeven, "Trade and Health 3: Trade and Social Determinants of Health," 373(9662) *The Lancet*, London, (Feb 7–13, 2009), pp. 504–505; Corinna Hawkes, Chantal Blouin, Spencer Hensen et al., *Trade, Food, Diet and Health: Perspectives and Policy Options*, Oxford, Wiley Blackwell, (2010) [hereinafter Hawkes et al., *Trade, Food, Diet and Health*].

[30] Corinna Hawkes, "The Influence of Trade Liberalisation and Global Dietary Change: The Case of Vegetable Oils, Meat and Highly Processed Foods," in Hawkes et al., *Trade, Food, Diet and Health*, pp. 35–59, p. 36.

[31] Hawkes, "The Influence of Trade Liberalisation and Global Dietary Change," pp. 55–56.

[32] Adam Drewnowski, Andrew Hanks, and Trenton Smith, "International Trade, Food and Diet Costs, and the Global Obesity Epidemic," in Hawkes et al., *Trade, Food, Diet and Health*, pp. 77–90.

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As in the tobacco context, some commentators also draw a connection between trade liberalization and increased marketing. This is sometimes associated with the term "coca-colonization," which refers to the spread of Western cultural and dietary influences through increased investment in marketing and other processes.[33] Not surprisingly, there is also a concern that food marketing is targeted toward children. One salient example can be found in the promotional toys offered with the sale of meals by fast food outlets.[34]

Any impact that liberalization may have on health will differ from place to place and from one risk factor to another. The necessarily harmful character of tobacco products means that liberalization is unlikely to be beneficial to health in any meaningful way. However, although liberalization of trade in alcoholic beverages may stimulate alcohol consumption, it may also offer some consumers access to beverages that are safer to consume than locally produced beverages. This may be the case, for example, where beverages are produced illegally or informally and contain methanol or other contaminants.

In the case of food, liberalization could increase food security and improve access to foods of high nutritional value, such as fruits and vegetables, on a year-round basis.[35] Other trade-related agricultural policies may also have a disparate impact on consumers. For example, it has been argued that the European Common Agricultural Policy (CAP) has kept prices in the European Union (EU) higher than international prices and that international prices have been suppressed by policies such as export subsidization.[36] Assuming a relationship between consumption and price, this would suggest that EU policy is likely to have suppressed consumption in the EU while stimulating consumption in food-importing countries. The relative costs and benefits of trade-related policies of this type will depend on a wide variety of factors. For example, export subsidies of this type may improve the nutritional status of a region facing undernutrition but may also stimulate overconsumption in regions not facing this problem.[37] Similarly, export subsidies on fresh fruits and vegetables may

[33] Tim Lobstein, "Tackling Childhood Obesity in an Era of Trade Liberalisation," in Hawkes et al., *Trade, Food, Diet and Health*, pp. 195–218.

[34] For a discussion of marketing targeting children in this context, see Lobstein, "Tackling Childhood Obesity in an Era of Trade Liberalisation," in Hawkes et al., *Trade, Food, Diet and Health*, pp. 198–203.

[35] Sophia Huang, "Global Trade of Fruits and Vegetables and the Role of Consumer Demand," in Hawkes et al., *Trade, Food, Diet and Health*, pp. 60–76.

[36] Josef Schidhuber and Prakash Shetty, "The European Union's Common Agricultural Policy and the European Diet: Is there a Link?" in Hawkes et al., *Trade, Food, Diet and Health*, pp. 131–147.

[37] Ibid., p. 145

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be expected to result in better nutritional outcomes outside of the EU than export subsidies on sweeteners such as sugar.

The impact of liberalization on health will also depend on the regulatory strategies adopted by domestic governments. An obvious response to the risk that liberalization will alter consumer preferences in a manner harmful to human health is the imposition of regulatory measures that counter these impacts. The GATT panel report in *Thailand – Cigarettes* reflects this idea.[38] Thailand had argued that a licensing system that effectively resulted in a closed tobacco market was necessary to protect human health from dangers such as the effects that market opening would have on consumption. The licensing system was not considered to be necessary for the protection of human health or life under Article XX(b) of the GATT.[39] Rather, the GATT panel held that Thailand could implement taxation measures and nondiscriminatory bans on tobacco advertising, and that these measures were reasonably available alternatives to the maintenance of the licensing system.

Equally, *Thailand – Cigarettes*, which was decided under the old GATT system, did not settle conclusively the extent to which the GATT or other WTO-covered agreements preserve domestic regulatory autonomy. In fact, some public health advocates have argued that the GATS limits the ability of WTO Members to restrict product advertising, because to do so may contravene market-access commitments for advertising service suppliers.[40] This reflects concerns about regulatory autonomy, which is the second point of tension between the trade regime and the new public health. For example, tobacco-control advocates have argued that trade agreements governing the implementation of nontariff barriers to trade limit domestic regulatory freedom to such an extent that comprehensive and effective tobacco control is not permitted.[41] Similar concerns are

[38] GATT Panel Report, *Thailand – Restrictions on Importation of and Internal Taxes on Cigarettes*, DS10/R, adopted 7 November 1990, BISD 37S/200 [hereinafter *Thailand – Cigarettes*].

[39] Ibid., paras 78–81.

[40] See, for example, Jim Grieshaber-Otto, Scott Sinclair, Noel Schacter, "Impacts of International Trade, Services and Investment Treaties on Alcohol Regulation," 95(Supplement 4) *Addiction*, (2000), pp. S491–S504; Ellen Gould, "Trade Treaties and Alcohol Advertising Policy," 26(3) *Journal of Public Health Policy*, (2005), pp. 359–376.

[41] See, for example, John Bloom, "Public Health, International Trade and the Framework Convention on Tobacco Control," Campaign for Tobacco-Free Kids, (March 2001) available at http://tobaccofreekids.org/campaign/global/framework/docs/Policy.pdf (visited 12/12/07); Cynthia Callard, Hatai Chitanondh, and Robert Weissman, "Why Trade and Investment Liberalisation may Threaten Effective Tobacco Control Efforts," 10 *Tobacco Control*, (2001), pp. 68–70 [hereinafter Callard, Chitanondh, and Weissman, "Why Trade"]; Cynthia Callard, Neil Collishaw, and Michele Swenarchuk, "An Introduction to International Trade Agreements

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held by some advocating increased government intervention to reduce harmful alcohol use and obesity.[42]

Differences in the regulatory contexts between infectious and noncommunicable diseases also raise questions about the adequacy of trade rules. For example, it is not clear how the overriding principle that trade-restrictive measures must be necessary to protect human health will be applied in the context of noncommunicable disease. In this respect, one important distinction between infectious and noncommunicable disease is the question of cause and effect. There is a clear causal relationship between the transmission of infectious diseases and harm to human health. For this reason, exposure to infectious diseases is often a proximal cause of disease, meaning that a risk factor acts either directly or almost directly to cause disease. In this context, it can be expected that there will be a close relationship between measures used to reduce transmission of infectious disease, such as import restrictions, and the protection of human health.

In contrast, the risk factors for noncommunicable disease are often more remote. Distal causes of disease are further down in the chain of causation. A compelling example of this can be found in the context of diet. Whereas consuming food-borne pathogens might directly result in disease, consumption of foods high in fat or sugar is likely to have a less direct impact on a person's health. Threats posed by high-fat food may not be as direct as threats posed by a food containing harmful pathogens. In the case of high-fat food, there is a longer chain of causation between consumption and the onset of disease, and there are likely to be a greater number of ways in which a WTO Member may address the risks.

Notwithstanding the differences in context between infectious diseases and the new public health, measures falling within each field are examined under the same legal framework of the WTO-covered agreements. The underlying requirement of this framework is that measures must be "necessary" for the protection of human life or health. The fact that this framework applies in both contexts raises a broader question concerning how that framework may or may not be suited to addressing the questions of concern.

and their Impact on Public Measures to Reduce Tobacco Use," Physicians for a Smoke Free Canada, (2001), available at http://www.smoke-free.ca/pdf_1/Trade&Tobacco-April%202000.pdf (visited 10/01/08) [hereinafter Callard, Collishaw, and Swenarchuk, "An Introduction"]; Robert Weissman, "International trade agreements and tobacco control: threats to public health and the case for excluding tobacco from trade agreements," (November 2003), v 2.0 available at http://www.fctc.org/x/cd/documents/EA_trade_backgrd.pdf (visited 26/11/07).

[42] See for example, Donald Zeigler, "International Trade Agreements Challenge Tobacco and Alcohol Control Policies," 25 *Drug and Alcohol Review*, (November 2006), pp. 567–579.

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Another issue that merits consideration is whether the WTO Agreement leaves sufficient policy space for WTO Members to address the link between economic specialization and poor diet. In this respect, the Global Strategy on Diet, Physical Activity, and Health emphasizes the need for local production of fresh produce.[43] At first glance, it is difficult to see how promoting local production, as opposed to importation, might benefit public health. However, some small island states have found that the lowering of trade barriers abroad has encouraged local farmers to produce single crops destined for export markets. This increased economic specialization has affected the availability of fresh fruits and vegetables, having a flow-on effect for traditional diets in places such as the Pacific Islands.[44] The relatively small markets in these states and the difficulties associated with shipping fresh produce to them may also be reasons for the failure of the market to ensure an adequate and affordable supply of fresh foods. Because food choices are made in the context of one's environment, issues such as price and availability are important and suggest that there may in fact be a compelling case for government intervention to ensure local production of certain foods. In this context, the lawfulness of subsidies for domestic production is worth considering. In addition, the limited budgets of many small island states suggest that other approaches, such as taxes and tariffs, may be the policy tools of choice.

At a more practical level, public health authorities continue to grapple with these questions of regulatory autonomy in their work. In 2007 the World Health Organization (WHO), in its role as chair of the United Nations Ad Hoc Interagency Task Force on Tobacco Control (of which the WTO is a member), called for further examination of the relationship between the international trade regime and global efforts aimed at tobacco control.[45] In the context of negotiations concerning illicit trade in tobacco products, World Health Organization Framework Convention on Tobacco Control (FCTC) parties have also been struggling to understand the implications of the WTO-covered agreements for measures to prevent illicit trade.[46]

[43] Global Strategy on Diet, Physical Activity and Health, World Health Assembly, WHA57.17, (May 2004), para. 41(3).

[44] Anne Marie Thow and Wendy Snowdon, "The Effect of Trade and Trade Policy on Diet and Health in the Pacific Islands," in Hawkes et al., *Trade, Food, Diet and Health: Perspectives and Policy Options*, Oxford, Wiley Blackwell, (2010), pp. 147–168, pp. 161–162.

[45] Report of the United Nations Ad Hoc Interagency Task Force on Tobacco Control, Conference of the Parties to the WHO Framework Convention on Tobacco Control, Second Session, A/FCTC/COP/2/4, 26 April 2007 available at http://www.who.int/gb/fctc/PDF/cop2/FCTC_COP2_4-en.pdf (visited 12/12/07).

[46] See, for example, Revised Chairperson's Text on a Protocol on Illicit Trade in Tobacco Products, and General Debate, Expert Review on a Possible Ban on Internet sales of

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There are two explanations for the gap in knowledge faced by public health officials. First, existing scholarship concerning application of WTO law to measures to prevent noncommunicable disease is very general in character and focused largely on the tobacco context. For example, a joint WTO and WHO study merely concluded that "[d]epending on how governments choose to manage trade in tobacco and tobacco products, a number of WTO rules could come into play."[47] Although general analysis of this type may be useful, as John Jackson has argued with respect to issues of linkage between the WTO and other regimes, the "devil is in the detail."[48] That is, there is a need for a more detailed analysis of the relationship between trade and public health.

The need for a fresh analysis of the issues is also highlighted by a number of contemporary controversies. At the time of writing, disputes concerning tobacco and alcohol are afoot: The panel in *Thailand – Customs and Fiscal Measures on Cigarettes from the Philippines*[49] is soon to hand down its report, the European Communities (EC) (now European Union) has requested consultations with India concerning taxes and other measures on imported wine and spirits,[50] and the United States has sought the establishment of a panel concerning taxes on distilled spirits in the Philippines.[51] Although these disputes appear peripheral to questions of domestic regulatory autonomy to protect health, other controversies appear to be more central to those concerns. For example, Indonesia has requested consultations with the United States concerning measures banning flavored cigarettes, including clove cigarettes produced in Indonesia.[52] The measure in question is said to relate to

Tobacco Products, WHO Framework Convention on Tobacco Control, Intergovernmental Negotiating Body on a Protocol on Illicit Trade in Tobacco Products, Third Session, Geneva, Switzerland, 28 June–5 July, 2009, FCTC/COP/INB-IT/3/INF.DOC./4, 7 May 2009.

47 WTO Agreements and Public Health: A Joint Study by the WHO and the WTO Secretariat, World Health Organization and World Trade Organization, (2002), available at http://www.wto.org/english/res_e/booksp_e/who_wto_e.pdf (visited 12/12/07).

48 John Jackson, "Fragmentation or Unification Among International Institutions: The World Trade Organization," 31 *New York University Journal of International Law and Politics*, (1998–1999), pp. 823–831, p. 823.

49 See *Thailand – Customs and Fiscal Measures on Cigarettes from the Philippines*, Request for the Establishment of a Panel by the Philippines, World Trade Organization, WT/DS371/3, 6 October 2008.

50 *India – Certain Taxes and Other Measures on Imported Wines and Spirits*, Request for Consultations by the European Communities, World Trade Organization, WT/DS380/1, G/L/855, G/SCM/D79/1, 25 September 2008.

51 *Philippines – Taxes on Distilled Spirits*, Request for Consultations by the United States, World Trade Organization, WT/DS403/1, G/L/914, 18 January 2010.

52 *United States – Measures Affecting the Production and Sale of Clove Cigarettes*, Request for Consultations by Indonesia, World Trade Organization, WT/DS406/1, G/L/917, G/SPS/GEN/1015, G/TBT/D/38, 14 April 2010.

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