

POLICY BRIEF: The Trans-Pacific Partnership and Health: Potential Risks and Benefits



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Introduction

This policy brief is based on a health impact assessment of the TPP agreement that we conducted between April 2014 and March 2016¹. Our study, undertaken by researchers employed through the Canada Research Chair in Globalization and Health Equity at the University of Ottawa, examined peer-reviewed evidence of the impacts of trade and investment agreements with provisions similar to those expected to be in the TPP, and involved Canadian and international experts in trade and health. In this brief, we first assess the direct health-relevant impacts of the TPP, including changes to drug costs, threats to expansion of public health insurance, and public health ‘regulatory chill’ related to investment protections through investor-state dispute settlement (ISDS). We then discuss some of the new barriers to public health regulation in the TPP that differ from existing Canadian trade agreements. Since public health protection involves far more than health systems alone, we finally examine the overall economic impacts of the TPP and their influence on health via the social determinants of health, especially changing income and employment dynamics.

Rising Drug Costs

One of the longest standing public health concerns with trade and investment agreements has been their potential impact on the price of pharmaceuticals. The TPP includes provisions in the intellectual property rights chapter that go beyond the World Trade Organization’s Agreement on Trade Related Intellectual Property Rights (TRIPs) and which lock Canada into extending patent protection through:

- patent term adjustments (extensions) of up to 2 years in Canada;
- loosening of terms for the re-patenting of existing drugs (for “new uses, new methods of using...or new processes”) with a recent study finding that device patents (“new methods of using”) are frequently used to extend patents beyond their normal expiry (1); and
- inclusion of 8 years of data/market exclusivity for biologics.

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The first-time inclusion of biologics (biopharmaceuticals made from living organisms) in a trade agreement is a public health concern as such drugs are expensive and increasingly important in the treatment of cancer and immune disorders.(2) One estimate of similar IPR concessions in the signed but not-yet ratified Canada–European Union Comprehensive Economic and Trade Agreement (CETA) (which did not include exclusivity provisions for biologics) suggests that Canadian conventional drug costs will increase by anywhere between 6.2% and 12.9% starting in 2023 (or by at least C\$800 million annually) when all provision have been fully phased in.(3) Finally, there are concerns about diminishing investments by pharmaceutical companies in new drug exploration and how this might be related to overly generous patent protections.(4) This has led a United Nations High-Level Panel on Access to Medicines to call for the development and production of health technologies and drugs in a way that better balances trade and industry interests with human rights and public health concerns.(5)

Health Systems and Investor-State Dispute Settlement (ISDS)

The TPP does not affect substantively the single-payer model of the Canadian health care system beyond our current level of exposure under the WTO’s General Agreement on Trade in Services (GATS) and NAFTA. Canada liberalized private health insurance as part of financial services commitments under GATS. This means that expansion of public health insurance into areas currently involving foreign private insurers with invested interests, especially if expansion took the form of full public funding, could trigger a WTO state-to-state dispute.(6) NAFTA, in turn, exposes Canada to a potential foreign investor dispute under Chapter 11 for similar expansion of publicly insured health care. The TPP extends this ISDS provision to a much larger number of foreign investors in the TPP’s Chapter on Investment.(7) This could lead to foreign-invested private health insurance providers launching costly investor-state claims against expansion of Canadian public health insurance into such areas as pharmaceuticals (‘pharmacare’) and home care. Such claims have already occurred under bilateral investment treaties with similar provisions as those in the TPP, including successful suits against Poland’s and Slovakia’s changes in their public health insurance and reversal of health-care privatization experiments.(8) Canada’s Annex II Social Services Reservation could shield against such a suit, but it rests on whether health insurance is considered by other TPP Parties or a tribunal to be “a social service established or maintained for a public purpose.” Even the threat of such a claim can induce governments to refrain from introducing new measures (‘regulatory chill’), as occurred most famously with Australia’s plain tobacco packaging law and, much earlier, Canada’s own withdrawal from plain packaging when told it would likely face a lawsuit under NAFTA’s Chapter 11 ISDS provisions.

Investor-State Dispute Settlement and the Tobacco Exclusion

Efforts by tobacco transnational firms to use both WTO and ISDS provisions in existing investment treaties to counter countries’ efforts to be compliant with the WHO’s Framework Convention on Tobacco Control led to a voluntary exclusion in the TPP from investor-state claims against any tobacco control measure. This is an ‘opt-in’ exclusion, since countries do not have to do so. Canada, in announcing its intention to follow Australia and other countries’ leads in introducing tobacco plain packaging, is presumed likely to invoke such an exclusion should the TPP enter into force. This exclusion is not a full carve-out, however, as it does not apply to

state-to-state disputes which could arise following pressure by tobacco interests on TPP governments. Nor does the exclusion prevent tobacco transnationals from using other investment treaties, such as NAFTA, to launch investor-state claims against Canada for new tobacco control measures. Nonetheless, the voluntary exclusion sends a strong, normative signal opposing investor-state disputes over tobacco control measures, and a tacit recognition that TPP governments are concerned with the potential impacts of ISDS provisions on public health regulations, at least with respect to tobacco. This recognition then begs the larger question: Why was this exclusion not extended to all non-discriminatory public health measures a country might adopt? This question is the more pertinent given the impact of processed food and alcohol products on health, and notably on the rise in obesity and non-communicable diseases; and especially so since the costs of defending against an ISDS challenge are rising,⁽⁹⁾ and represent lost public investment in domestic measures that might otherwise promote health.

Barriers to Public Health Regulation

In addition to potential ISDS threats, the TPP has provisions that could create new barriers to public health efforts to regulate health-harmful commodities. The TPP incorporates much of the WTO's Agreement on Sanitary and Phytosanitary Measures (SPS), including a deferral to the *Codex Alimentarius Commission* for international standards on food safety. The Codex is tasked with protecting the health of consumers while ensuring fair practices in food trade. The TPP SPS Chapter goes further, however, by requiring that such standards also "facilitat[e] and expand...trade" (art.7.2.a), requirements that were never the intent of the Codex. The requirements for a Party, such as Canada, to exceed international standards has also been changed in the TPP. The WTO SPS agreement allows regulations to exceed Codex standards "if there is scientific justification" (art 3.3). This WTO requirement has been criticized for shifting the intent of the Codex from creating a regulatory floor (no one should regulate less) to providing a regulatory ceiling (above which scientific justification is needed). The WTO SPS, however, allows for a 'scientific minority' opinion to satisfy this requirement, affording some latitude for the important public health precautionary principle. The TPP appears to undermine this latitude by requiring non-conforming standards to be "based on documented and objective scientific evidence" (art.7.9), arguably a tougher test for public health regulators to meet, especially when not all possible risks have that level of evidence at the time of a need for new regulation.⁽¹⁰⁾

In similar fashion, the TPP's Chapter on Technical Barriers to Trade (TBT) incorporates much of the WTO's TBT agreement, but adds additional provisions. Unlike the WTO's TBT, the TPP's TBT chapter requires Parties to ensure that when developing new "international standards, guides and recommendations ... [these] do not create unnecessary obstacles to international trade" (art.8.5.3). Like the "facilitating and expanding trade" addition in the TPP's SPS chapter, this TBT provision could effectively place trade concerns ahead of standards intended to protect consumer health and safety or the environment. The TBT also creates new avenues for vested interests to influence the creation of such standards, allowing "persons" from each of the TPP Parties to participate in their development "on terms no less favourable than those it accords to its own persons" (art.8 .7.1). A 'person' could be an individual or a multinational corporation.

Given recent past efforts of transnational food corporations to avoid regulations on sugar, fat, or other health-compromising components of what have been called obesogenic foods, this provision could lead to regulatory capture.(11)

The TPP's Regulatory Coherence Chapter, the first time such a chapter has appeared in a trade agreement, caused considerable initial public health concern over the additional notification, reporting and response requirements it places on Parties when they consider new regulatory measures. Like the TPP TBT chapter, it opens up to "interested persons of the Parties to provide input on matters relevant to enhancing coherence" (art25.8). Whether this leads to a preponderance of private sector (over public interest and public health) input remains moot. That this chapter is excluded from dispute settlement provisions, however, signals that it functions more as a place-holder for future agreements, than an immediate public health regulatory concern.

Health Exceptions in the TPP

Governments have responded to these public health concerns by pointing to health exceptions within the TPP as providing adequate protection for regulations concerning health or the environment. The TPP's TBT chapter is assumed to be governed by the same provisions as those under the WTO's GATT XX (b), which read: "Subject to the requirement that such measures 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, nothing in this Agreement [the GATT] shall be construed to prevent the adoption or enforcement by any contracting party of measures: ... (b) necessary to protect human, animal or plant life or health;..." While a potentially useful exception, in the history of its invocation under the WTO dispute system it has been successful only once in 43 cases (France's ban on Canadian asbestos exports), with the largest number of cases failing on the so-called 'necessity test'.(12) Moreover, the TPP's provision in the TBT 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" (art.8.3.5) is circular, essentially saying that Parties are able to regulate all they want so long as they abide by the restrictions of the TBT chapter.

Of greater regulatory worry is the similarly circular reasoning in the general exception in the TPP's ISDS chapter, which states that: "Nothing in this Chapter shall be construed to prevent a Party from adopting, maintaining or enforcing any measure *otherwise consistent with this Chapter* that it considers appropriate to ensure that investment activity in its territory is undertaken in a manner sensitive to environmental, health or other regulatory objectives" (art.9.1.5). The italicized wording essentially negates this regulatory protection. More regulatory latitude is offered in an Annex to the Investment chapter, which states that "Non-discriminatory regulatory actions by a Party that are designed and applied to protect legitimate public welfare objectives, such as public health, safety and the environment, do not constitute indirect expropriations, except in rare circumstances" (Annex art.3.b), although this still leaves the determination of a 'legitimate' objective and a 'rare circumstance' to the decisions of a tribunal comprised of three investment lawyers with little concern for public interests. Moreover, a clarifying footnote provides examples drawn solely from medical care and is silent

on broader public health concerns such as those relating to health-harmful products, including tobacco, alcohol and ultra-processed food products.

In sum: We consider these TPP health exceptions to be inadequate in terms of protecting public health regulatory and policy space to cope with those health risks presently known, and especially those that may yet arise.

ISDS Procedural Flaws

The public health concern with the interpretation of ISDS health exceptions rests, in part, in well-documented flaws with current ISDS procedures. Such procedural flaws have been recognized by the Canadian government in the case of the Comprehensive Economic and Trade Agreement (CETA), and include: how ISDS shifts power of domestic and international courts to unaccountable and for-profit arbitrators; lack of institutional safeguards of independence and fairness of arbitration process; and inability to appeal rulings by the tribunal. In response to such criticisms, Canada agreed to revamp the ISDS system set out in CETA into an “Investment Court System” during the legal scrubbing of the treaty. However, despite such changes, the European and German Association of Judges have criticised the revamped “Investment Court System”, pointing to a lack of legal basis for its establishment and affirming that the provisions for the election, time of office and remuneration of the “judges” do not meet the minimum standards for judicial office.⁽¹³⁾ What is more, there are serious concerns that nothing will change in practice, with for-profit adjudicators continuing to apply the same deeply flawed and imbalanced investor rights. A recent study by CCPA identified five iconic and controversial investor-state dispute settlements, where environmental and public health protections have been attacked, and reviewed them through the lens of the revamped “Investment Court System”. The report finds that all five disputes could still happen under the new system, which, even if these CETA amendments were able to be written back into the TPP in the guise of finalizing a code of conduct for ISDS arbitrators, they would still fall short of safeguarding a government’s right to regulate.⁽¹⁴⁾

Overall Economic (Health) Impacts

The above analyses constitute some of the more apparent health risks. We accept that there are potential health gains as well. Chief amongst these are the positive health externalities that may be associated with the economic growth and employment gains that are frequently claimed to follow from further trade and investment liberalization. The actual health impact will depend on the redistributive effects of such growth. To the extent that economic gains benefit all countries, are substantial and ‘trickle down’ in a somewhat equitable fashion to all workers (and do so without undermining efforts to achieve the new Sustainable Development Goals and their focus on environmental integrity) there is a potentially powerful health gain in people accumulating more of the resources needed to lead a healthy life. However, most expert assessments attribute little economic impact to the TPP. A widely cited study, including by the Government of Canada, by the Peterson Institute predicts only 0.2% GDP growth in addition to what the economic trend would have been without the existence of the TPP over the same period.⁽¹⁵⁾ Another study by the C.D. Howe Institute comes to a similar conclusion, attributing only a 0.08% GDP increase to the TPP in 2018 if fully implemented, with additional output rising

to about 0.08 percent by 2035.(16) These estimates have been described as little more than rounding errors. Even the most recent estimate, from the U.S. International Trade Commission, found that, for the US economy, the net GDP gain after 16 years of TPP will be only 0.23% which, as the co-director of the Center for Economic and Policy Research summarized means that “as a result of the TPP, the country will be as wealthy on January 1, 2032 as it would otherwise be on February 15 of 2032”.(17)

All of the above estimates use some form of computable general equilibrium (CEG) modelling, which assumes full employment (any worker who loses employment in a sector negatively affected by the new agreement is immediately employed in a sector positively affected); income distribution constant or improving; no impacts on trade balances; and little or no consideration of negative costs, such as those that might arise from higher drug prices or public expense to mitigate the trans-border spread of health or environmental risks (e.g. invasive species, increased anti-microbial resistant pathogens). Such modelling in defense of an oft-claimed 21st century ‘gold-standard’ agreement, in a period now that many economists are arguing marks an end to global growth and employment as we have experienced it over the past 50 years, and where global wealth inequalities continue to increase to levels never before experienced, is disconcertedly limited.

Alternative econometric models based on more realistic, dynamic assumptions, which acknowledge that not all sectors of the economy will be impacted equally by the TPP (which is the position of the Canadian government), come to quite different conclusions. A recent study using the United Nations Global Policy Model database predicts utterly negligible GDP changes (+0.03% annually) in the case of Canada, but it also predicts a loss of 58,000 jobs attributed directly to the TPP.(18) The study then shows that income and wealth inequalities are likely to increase under the TPP, as the share of GDP going to capital will rise while the share going to labour will decline. This finding is similar to another U.S. study that estimated small wage declines for the bottom 90% of American workers, and larger wage increases for the top 1% of wage earners.(19) This link between “free trade” and growing income inequality is now well established in the policy and academic literature, as, for example, in a recent analysis of NAFTA’s impact on Canada.(20) Any such rise in inequality can indirectly undermine population health through a worsening distribution in the social and environmental resources people need to lead healthy lives.

Conclusion

Trade between population groups (later nations) has long been a feature of human societies. The international dimensions of trade is more recent, with the rise of nations and the transportation technologies that allowed for more rapid movement of goods. Trade can bring enormous benefits for health; it has also been historically a vector for the spread of infectious diseases (a risk that has re-assumed importance) and, with corollary investment liberalization, more recent shifts in diets that have globally diffused food-related (obesogenic) health risks.(21) Some of these risks may be mitigated through effective national-level public health regulation. While flexibilities for such regulation can still be found in contemporary trade and investment agreements, including the TPP, new provisions risk impeding governments’ abilities to maximize public health protection without running afoul of what are essentially commercial

agreements. More importantly, there is no evidence that the TPP will substantively benefit most workers in most TPP countries. There is one notable exception, Vietnam, but with the *caveat* that employment gains in that country derived primarily from preferential access for its textiles in TPP markets is at the cost of employment losses in other low- and lower-middle-income countries competing for the same markets.(18)

Given the marginal new welfare gains, the potential for negative environmental impacts associated with increased transportation of goods, and the likelihood that the TPP will increase rather than decrease income inequalities within most TPP Parties, we do not consider the public health risks embedded within the new treaty to be sufficiently offset by any apparent health gains. Without clearly defined equitable economic and health benefits, treaties such as the TPP risk accelerating the recent rise in forms of protectionism and xenophobia that, historically, have been precursors to major conflicts or wars.

We call on the Committee to recommend against ratification of the TPP, and to create a new, transparent and nation-wide dialogue on what trade and investment treaties for the 21st century should look like, in light of our new obligations under our the post-2015 Sustainable Development Goals, the 2015 Paris Accord on Climate Change and our longer-standing obligations under international human rights conventions. We remind the Committee of the visionary promise on which the multilateral World Trade Organization was founded:

“to raising standards of living, ensuring full employment and a large and steadily growing volume of real income and effective demand...while allowing for the optimal use of the world’s resources in accordance with the objective of sustainable development”.(22)

There is little in the present TPP to suggest that these outcomes would be achieved.

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