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Article

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MULTIPOLARITY, INTELLECTUAL PROPERTY, AND THE INTERNATIONALIZATION OF PUBLIC HEALTH LAW

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*716 INTRODUCTION

The cause of global health today is arguably the most influential human rights movement ever seen, mobilizing vast flows of direct and indirect aid to the developing world to fight disease and build health care infrastructure; prompting the establishment of international organizations like UNAIDS and the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund); including global health as a priority in major diplomatic summits; and driving the formation and implementation of international agreements to address global health threats. Champions of this movement claim that the diverse and influential state and non-state actors participating in the development of the global health regime are evidence of its normative, law-making power. Speaking of a range of initiatives undertaken by the World Health Organization (“WHO”), Christopher McDougall, Ross Upshur and Kumanan Wilson wrote that:

Each . . . reflects a revolutionary willingness of the international community to accept new forms of supranational authority and to abide by the principle that national sovereignty can in some circumstances be subordinate to public health protection. As such, *717 they are integral parts of the evolution of international health governance towards a global public health security regime.¹

In 2007, the governments of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand issued the Oslo Ministerial Declaration declaring that:

The early 21st century . . . has seen an unprecedented convergence of global health and foreign policy . . . [e]nsuring public health on a global scale is of benefit to all countries. Powerful synergies arise when national interest coincides with the need for concerted regional and global action.²

Indeed, the evidence for the normative strength of the global health movement is persuasive. From 1995 to 2010, the value of goods and services aimed at improving global health increased at least threefold.³ Global health was introduced as a priority at the 26th G8 Summit--giving rise to the Global Fund--and has remained on the agenda ever since.⁴ Since 2005, states have updated the International Health Regulations (“IHR”) to coordinate broader responses to more diseases and have concluded the first international public health treaty, the Framework Convention for Tobacco Control (“FCTC”).

Yet that evidence is also deceiving. The 2005 IHR, concluded in the wake of outbreaks of diseases largely in developing countries, appeared to falter on the unwillingness of wealthy countries to equitably address vaccine production and distribution. Key provisions of the FCTC have failed in the face of challenges tobacco firms have mounted on the basis of their rights in trademarks and brands. Indeed, formal global health instruments that purportedly capture the health movement's normative force have been systematically undermined by a competing global movement: international intellectual property protection.

Intellectual property rights and public health interventions are in many ways natural antagonists. The exclusive control given pharmaceutical *718 patent holders, while theoretically required to encourage investments in research and

development, stands at odds with access to affordable medicines. The goodwill trademark proprietors build through investments in advertising and marketing often trades off with costs imposed upon society through excessive or deceptively-induced consumption.⁵ This antagonism has long played out in the domestic context, where lawmakers conditioned intellectual property rights on their relationship with other national health priorities. India, for example, prohibited pharmaceutical patents for most of its history, a decision driven by the need to facilitate access to affordable medicine for its massive population.⁶

While national politics played the major role in deciding the balance between intellectual property protection and public health priorities, international agreements governing intellectual property and international public health issues tended to acknowledge the threat strong IP protections posed for public health measures. The Paris Convention for the Protection of Industrial Property, for example, allowed states to invalidate or refuse to register trademarks that misled or deceived consumers and left states free to grant compulsory licenses for reasons of public health. In any case, international IP and international public health instruments have depended on traditional diplomatic compliance mechanisms like good faith fulfillment of obligations, consultations in the event of a dispute and tit-for-tat sanctions.⁷ In short, they were enforced, often weakly, at the state-to-state level.⁸

In the last 30 years, the global movement to elevate the international legal status of intellectual property rights has also achieved substantial gains. Industrialized states successfully tied intellectual property protections they desired to the reductions in tariffs and other barriers to imports of foreign agricultural, clothing and textile goods sought by many developing countries, formalized in the WTO Agreement on Trade-Related Aspects of Intellectual Property (“TRIPS”). Thousands of bilateral investment treaties, largely forged between developed states and developing states, included strong protections for intellectual property rights that frequently exceeded those in existing international agreements, even TRIPS, and certainly beyond those typically found in national legislative frameworks.⁹

Yet, unlike the earlier era when IP rights and international public health law were roughly equivalent in their limited influence, the expansion of international public health law has proceeded with its explicit and implicit subordination to IP rights. For example, TRIPS provides a general authorization for parties to “adopt measures necessary to protect public health” but requires that “such measures are consistent with the provisions” of TRIPS.¹⁰

The confrontation between the growing strength of international intellectual property law and national public health measures is well-documented. Even before TRIPS, IP rights holders successfully used international agreements to thwart domestic public health policies. Contesting Australia's 1992 effort to require tobacco manufacturers to sell cigarettes in plain packaging, British American Tobacco argued before the Australian Senate that such a law would violate both the Paris Convention for the Protection of Industrial Property and the Australian Constitution.¹¹ Persuaded by the tobacco industry, the Australian government rejected the proposed regulations.¹² In 1994, Philip Morris and RJR Reynolds undertook a similarly successful campaign in Canada based in significant part on the intellectual property protection provisions of NAFTA. In 1998, pharmaceutical firms holding the patents to antiretroviral drugs in South Africa brought suit against the government for its efforts to use parallel imports and price controls to expand access to treatment for its exploding HIV/AIDS population.¹³ Their suit was based in significant part on the failure of the government's legislative basis for the measures to comply with TRIPS. The firms ultimately relented, although with guarantees by South Africa to respect TRIPS obligations.¹⁴

The purpose of this Article is to argue that international intellectual property law has not only erected substantial barriers to domestic or national measures taken in the interest of public health, but that intellectual property protections

embedded in a wide range of investment, trade and IP treaties have substantially undermined existing and proposed international public health law. From vaccine development orchestrated by WHO (acting under the authority of the IHR) to the marketing of breast-milk substitutes to pregnant and nursing mothers in developing countries to efforts by national authorities to implement provisions of the FCTC, international ***721** intellectual property law has systematically curtailed the intended population health benefits promised by effective implementation of these agreements.

Indeed, to the extent international public health agreements have influenced the conduct of states party to such agreements, I argue that they have done so not because of the normative force the global health movement has exercised on foreign policy, but precisely because of politics as usual. The efforts of states like Brazil, India, Indonesia, South Africa, and Thailand in securing affordable access to medicines and vaccines, enforcing international marketing codes, and fending off IP-based challenges to new public health interventions represents one manifestation of a world in which the centers of hard and soft diplomatic power are diffusing from Europe and North America to Africa, Asia and South America.¹⁵ In areas from arms control to climate change, this phenomenon is generally known as “multipolarity,” distinguishing the bipolar Cold War rivalry between the U.S. and the U.S.S.R. and harkening back to nineteenth century European politics dominated by Great Powers and characterized by an ultimately unstable balance of power between them.¹⁶

On the one hand, this trend should encourage international public health law advocates because it increases the likelihood that international public health agreements will achieve at least partial population health gains through unilateral or coordinated action by middle income states. On the other hand, the fact that international public health law is so frail in its confrontation with international IP agreements reveals the weak role norm creation is playing in the context of international public health law. The Article argues that as international public health advocates press for agreements covering a wider range of issues like alcohol control, medical research and innovation, and even a comprehensive convention on global health, they must confront obstacles posed by international intellectual property law more squarely than they now do, as well as shape their agenda in light of the shifting alignment of global economic and political power.

Part I of this Article traces the history of international public health law as it evolved from a loose network of politicized (and subsequently ineffective) international treaties in the late nineteenth century to a comprehensive movement toward a regime of conventions and protocols addressing the prevention and management of health threats that cross international borders.

***722** Part II traces the parallel history of international intellectual property protections beginning with the 1883 Paris Convention for the Protection of Industrial Property and growing to include a wide network of bilateral, regional and multilateral investment and trade treaties.

Part III identifies episodes beginning in 1994 and concluding in 2012, when these movements collided over a range of international public health law instruments: the 1981 WHO Guidelines on the Marketing of Breastmilk Substitutes, the 2005 International Health Regulations, and the 2005 Framework Convention on Tobacco Control. These episodes, in turn, foreshadow likely conflicts should proposals for a Framework Convention on Alcohol Control or an even wider-reaching Framework Convention on Global Health materialize. These episodes illustrate the weak role of international public health law in shaping states' behavior.

Part IV recommends solutions to the current problems, including the strengthening of public health exceptions in bilateral investment treaties, the withdrawal of certain dispute resolution procedures across a wide range of treaties, the explicit management of intellectual property rights in future international public health agreements, and the crafting of a global

public health agenda that focuses on political practicalities as shifts in global power change the strength and influence of developing states.

I. THE INTERNATIONALIZATION OF PUBLIC HEALTH LAW

The end of the 20th century ushered in the era of global public health. In this “global health revolution”¹⁷, states have not only revised and expanded the IHR and established the FCTC, but they have also re-oriented developing states' public health policy trajectories through their aid programs (like the U.S. President's Emergency Relief for Aids in Africa (PEPFAR)) and the development of health diplomacy. Major non-governmental organizations like the William J. Clinton Foundation (now the Bill, Hillary and Chelsea Clinton Foundation), the Bill and Melinda Gates Foundation, and the Bloomberg Family Foundation have also allocated significant and influential parts of their giving to the alleviation of global public health threats ranging from malaria to tobacco use. Other major international legal efforts lie in wait, like the American Public Health Association's call for a Framework Convention on Alcohol Control and even more ambitious proposals like a Framework Convention on Global Health.¹⁸

*723 Theoretically, this revolution represents the growing acknowledgment that economic development depends on a population that enjoys access to a basic level of health care and attention to conditions that accommodate individual and public health, the “right to the highest attainable standard of physical and mental health” under international human rights law.¹⁹ Practically speaking, the growth of international public health law is a response to a globalized world of health threats including disease outbreaks that cross international borders, food security and safety under liberalized investment and trade rules and the worldwide marketing of products like tobacco, alcohol and processed food that pose unique challenges for the management of cancer, diabetes, heart disease, hypertension and strokes.²⁰ The economic and human cost of these burdens is vast and growing.²¹ The emergence of HIV/AIDS in the 1980s as well as increasingly threatening strains of influenza brought into vivid focus the inadequacy of existing international coordination mechanisms to handle infectious diseases, including the manufacturing and distribution of medicines and vaccines.²² Not only did the 1969 International Health Regulations only cover cholera, plague and yellow fever, but they also lacked meaningful requirements for states to “detect, report, and respond to public health events of international concern.”²³ For example, tobacco consumption, *724 the principal preventable threat to individual and public health in both developed and developing countries, annually kills approximately five million people worldwide and is expected to kill one billion people in this century, if current trends persist.²⁴ Liberalized trade and investment rules have shifted the massive disease burden from tobacco consumption from developed to developing countries.²⁵ Indeed, this shift explains in part the origin of the FCTC.²⁶

Similarly, the World Health Organization points to processed foods heavily marketed toward children, expanding consumption of fast foods and sugary beverages, as important factors in the emerging global obesity epidemic.²⁷ Obesity levels are rising throughout both developed and developing countries, playing some causative role in heart disease, diabetes, certain cancers, osteoarthritis and strokes.²⁸ The scope and strength of international instruments targeting these threats has correspondingly expanded.²⁹

*725 This expansion, what I refer to as the internationalization of public health law, conceivably includes agreements and political commitments made across several issue-areas.³⁰ For example, the 1949 Geneva Conventions codified customary rules requiring access of medical personnel to the injured and sick during armed conflicts and guaranteed prisoners of war access to some level of health care. Similarly, arms control treaties like the NPT, the Biological

Weapons Convention and the Chemical Weapons Convention are theoretically driven by those weapons' potentially devastating effect on human health and life.³¹ The 1978 Alma Ata Declaration and the 1993 Vienna Declaration and Programme of Action marked important turning points in the history of the right to health without formalizing any express commitments by governments.³² Indeed, judges, scholars, human rights activists and law-makers have never agreed upon the content of the right to the highest attainable standard of health since its codification in international human rights treaties.³³ For purposes of this Article, I limit the internationalization of public health law to international legal regimes designed to address health threats, specifically those undertaken by the World Health Organization and its predecessor, the International Sanitary Conventions.

726 A. *The International Sanitary Conventions

The internationalization of public health law began with an effort to coordinate national efforts to contain disease. In the middle of the nineteenth century, states maintained their own standards for inspection and quarantine of foreign goods and peoples that posed public health threats, especially cholera.³⁴ Between 1851 and 1892, predominantly European powers met in an effort to conclude a list of internationally actionable diseases and the appropriate methods by which their spread might be limited. The health positions taken by participating governments and medical delegates were inevitably politicized, as the etiology of each disease (and therefore its containment) necessitated measures that affected the commercial interests of each state.³⁵ Britain, for example, persistently opposed measures that imposed significant burdens on maritime trade.³⁶

Nevertheless, in 1892 the first International Sanitary Convention (“ISC”) was concluded, which aimed to monitor westbound shipping through the Suez Canal.³⁷ Between 1893 and 1903, four more international conventions were convened, steadily expanding the diseases deemed appropriate for cooperation and control, the international adoption of national policies for surveillance; quarantine of certain items and persons; processes for sterilizing goods suspected of facilitating infection, and the notification requirements for other participants. At the 1903 convention, delegates agreed both on the need to codify in a single instrument the preceding agreements as well as to establish an international health organization.

These objectives of the 1903 ISC continued through the conventions held in 1912, 1926 and 1938. During this time, two international health organizations were established and the 1903 ISC was updated to reflect advances in the control of infectious diseases. At that time, “numerous international legal regimes addressing public health issues arose, particularly treaties dealing with . . . opium and alcohol, occupational hazards, and transboundary pollution.”³⁸ As historians of the ISC conferences observed, over time the agenda of the international meetings moved from coordinating European responses to disease threats originating from Asia to serving as an important forum for clinical researchers, bacteriologists, physicians and other medical researchers to influence international law and international relations as they affected the spread of disease.

***727** The treaties' stated objectives tended to go unfulfilled. For example, it took seven international conventions meeting between 1851 and 1892 to finally generate the International Sanitary Convention of 1892, which was limited to cholera.³⁹ The eleventh International Sanitary Convention succeeded in creating an international health organization, the Office International d'Hygiène Publique, but it “had no authority to do field work within a particular country, even at that country's request.”⁴⁰ In its 2005 revision of the International Health Regulations, the WHO's Intergovernmental Working Group noted that the IHR had been developed “to replace the largely ineffective international sanitary conventions, which were hampered inter alia by a lack of consistency and uniformity in their implementation.”⁴¹ The

purposes of the conventions became less legal in a strict sense and more technocratic, changes which were to foreshadow the behavior of the World Health Organization upon its establishment in 1948.⁴²

B. The World Health Organization

When international lawmakers established the World Health Organization, they intended to give it strong law-making and regulatory authority.⁴³ Article 19 of the WHO Constitution authorized it to conclude treaties within its broadly worded mandate, while Article 21 gave the World Health Assembly the authority to adopt legally binding recommendations in five discrete areas: sanitary and quarantine regulations; nomenclatures on diseases, causes of death, and public health practices; standards for diagnostic procedures for international use; standards for safety, purity, and potency of biological, pharmaceutical, and similar products moving in international commerce; and advertising and labeling of biological, pharmaceutical, and similar products moving in international commerce.⁴⁴ In addition, Article 22 established the binding legal effect of these regulations *728 unless states opted out of them within the notification period, an innovation that collapsed the usual drawn-out ratification process historically experienced in the international law-making process.⁴⁵

Instead of exercising its formal legal authority, WHO embarked upon several decades of technocratic observation, advising and support.⁴⁶ The World Health Assembly updated the International Sanitary Regulations in 1969, but the scope and strength of the IHR were minimal.⁴⁷ WHO focused on epidemiological and technocratic expertise, giving itself a central coordinating role between other international and non-governmental organizations and making far more frequent use of its Article 23 recommendation-issuing authority.⁴⁸ The World Health Assembly regularly issued resolutions advising governments to undertake a range of measures related to its highly regarded epidemiological work, but steered almost completely clear of its law-making and regulation-issuing authority.⁴⁹ These resolutions covered a wide range of areas, from the marketing of breast-milk substitutes (and maternal and child health more generally) to the detection and prevention of infectious diseases to tobacco control.

1. International Code on the Marketing of Breastmilk Substitutes

After the 1969 IHR, WHO aimed at using its Article 21 powers to address child malnutrition in the International Code on the Marketing of Breastmilk Substitutes, although the policy eventually took form as an Article 23 recommendation. In 1974, the World Health Assembly acknowledged *729 the declining rate of mothers exclusively breastfeeding for the first six months of life, the period WHO recommends for both maternal and child health.⁵⁰ The recommendation is not driven by nutritional variations between breastmilk and infant formula, but by the risks inherent in mixing (especially with contaminated water) and administering formula as well as the malnutrition that accompanies improper or imbalanced substitutes. As Ted Kennedy phrased it:

Can a product which requires clean water, good sanitation, adequate family income and a literate parent to follow printed instructions be properly and safely used in areas where water is contaminated, sewage runs in the street, poverty is severe and illiteracy high?⁵¹

The evidence is persuasive: 13% of the 10.9 million deaths of children younger than 5 years could be prevented every year if universal protection, promotion and support of breastfeeding were achieved.⁵² In addition, breastfeeding plays a role

in spacing pregnancies where contraception is unavailable or contraception failures are common. The declining rates of breastfeeding were attributed to food firms' aggressive marketing of infant formula, other milk products, cereals for infants, vegetable mixes, and baby teas and juices, all of which fall under WHO's definition of breastmilk substitutes.⁵³ These firms' marketing practices either asserted or implied nutritional and other health equivalencies with, or superiority to, exclusive breastfeeding.

Between 1977 and 1979, children's malnutrition became a priority for the World Health Assembly and WHO began working with UNICEF on a framework for "regulating inappropriate sales promotion of infant foods that can be used to replace breast milk."⁵⁴ Those discussions revolved around five themes: the encouragement and support of breastfeeding; the promotion and support of appropriate and timely complementary feeding (weaning) practices with the use of local food resources; the strengthening of education, training and information on infant and young child feeding; the promotion of the health and social status of women in relation to infant and young child health and feeding; and the appropriate marketing and distribution of breast-milk substitutes. In 1980, the World Health Assembly endorsed the WHO/UNICEF findings and recommended that "there should be an international code of marketing of infant formula and *730 other products used as breast-milk substitutes." In early 1981, WHO endorsed a draft of the Code and recommended it to the World Health Assembly, which adopted it by an overwhelmingly vote.⁵⁵

The International Code seeks to prevent companies from advertising; implement strict labeling requirements, including a proscription on infant images or other pictures which idealize breastmilk substitutes; limit influence on health care workers; and, prohibit distribution of free samples of breast milk substitutes.⁵⁶ The International Code, together with subsequent recommendations, is not a binding treaty, but represents an evidence-based minimum standard that informs human rights obligations.⁵⁷ Eighty-four states have enacted legislation implementing all or some aspects of the International Code while another fourteen have legislation pending.⁵⁸ Since the International Code's adoption, food firms have systematically exploited its ambiguities and have directly challenged labeling provisions that diminish intellectual property rights in trademarks and tradenames.⁵⁹

2. International Health Regulations

The 1980s and early 1990s witnessed the emergence of new infectious diseases like HIV as well as the resurgence of older diseases like cholera. In 1995, the World Health Assembly instructed WHO's Director General to revisit the IHR precisely because the regulations neglected "the emergence of new infectious agents" and failed to provide for an adequate response to those that were covered.⁶⁰ The World Health Assembly attributed these failures to the erosion of barriers between goods and people.⁶¹ The protracted IHR revision process overlapped with acrimonious *731 negotiations between developing and developed states over the inclusion of intellectual property protections in the global free trade regime.⁶² In 2003, the outbreak of SARS--and the hesitation of the Chinese government to report or contain it-- facilitated the 2005 revisions.⁶³

The IHR (2005) was revised to encompass the detection and prevention of all infectious diseases.⁶⁴ Their scope was expanded "to include any event that would constitute a public health emergency of international concern."⁶⁵ "The Regulations now encompass public health risks whatever their origin or source (Article 1.1), including: (1) naturally occurring infectious diseases, whether of known or unknown etiological origin; (2) the potential international spread of non-communicable diseases caused by chemical or radiological agents in products moving in international commerce; and (3) suspected intentional or accidental releases of biological, chemical, or radiological substances."⁶⁶

Acknowledging the importance of communication and cooperation to successful detection and prevention of communicable diseases, States Parties are obligated to “develop the means to detect, report, and respond to public health emergencies . . . and establish a National IHR Focal Point [NFP]⁶⁷ for communication to and from WHO.”⁶⁸ State Parties must inform WHO within 24 hours of an assessment of any event that could be considered a “public health risk to other States requiring a coordinated international response.”⁶⁹

The drafters of the IHR (2005) included important limitations on the measures states could impose when facing a public health “event.”⁷⁰ These limitations may be categorized in two non-mutually exclusive ways: 1) individual human rights and 2) the harmonization of the IHR with other international agreements. Individual rights, especially those historically *732 characterized as “civil” or “political,” often faced curtailment in the name of public health measures. Isolation and quarantine, for example, impose significant restrictions on individual liberty. Under the IHR (2005):

For a public health measure to restrict a civil and political right lawfully, the measure must (1) respond to a pressing public or social need; (2) pursue a legitimate aim; (3) be proportionate to the legitimate aim; and (4) be no more restrictive than is required to achieve the purpose sought by restricting the right. The rights-restricting measure must also be implemented in a non-discriminatory manner (International Covenant on Civil and Political Rights (ICCPR), Articles 2.1 and 26).⁷¹

State Parties may implement health measures that achieve the same or greater level of health protection as WHO recommendations. However, they must be based on scientific principles, available scientific evidence, relevant guidance or advice from WHO, and cannot be more restrictive of international traffic or more invasive or intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection.⁷²

These provisions are explored, *infra*, as dovetailing with health exceptions and rules of interpretation provided in WTO agreements, especially TRIPS. Because the 2005 IHR do not have a strong enforcement mechanism,⁷³ this ultimately privileges WTO jurisprudence as the benchmark by which public health measures that states implement are evaluated.

Indeed, during the IHR negotiation process:

WHO member states expressed concerns that the expanded scope of the new IHR would bring the Regulations into conflict with other international agencies and treaties that addressed cross-border health risks - e.g., the International Atomic Energy Agency (nuclear accidents); the World Trade Organization (health measures that restrict international trade); and the Codex Alimentarius Commission (food standards and guidelines to protect consumer health and promote trade in safe products). WHO addressed these concerns by demonstrating that few conflicts existed; amending the negotiating text to remove the small number of possible conflicts; and adding provisions to facilitate cooperation and coordination between WHO and other international organizations (e.g., Articles 14, 17(f), 57.1).⁷⁴

*733 The first meaningful test of the 2005 IHR occurred in the context of the outbreak of the H1N1 influenza virus in 2009, although the outbreak of avian flu in Indonesia in 2007 also tested the IHR's underlying principles. These episodes demonstrated the confrontation between intellectual property and public health as well as the role middle-income states

played in advancing the public health agenda. In 2007, Indonesia refused to share flu samples precisely because of past experiences in which Western firms patented genetic material in order to manufacture unaffordable vaccines.

3. The Framework Convention on Tobacco Control

Parallel to negotiations over the revised IHR, the World Health Organization also oversaw the drafting of its first public health treaty, the Framework Convention on Tobacco Control (“FCTC”). Just as the surge in old and new infectious agents--tied in a significant way to globalization--prompted calls for an improved set of International Health Regulations, the FCTC represented the culmination of decades of public health measures recommended by the World Health Assembly but persistently undermined by a globally-coordinated effort undertaken by tobacco firms.⁷⁵

In 1995, Canada, Finland, Mexico, and Tanzania supported the idea of an international agreement⁷⁶ to regulate tobacco at the World Health Assembly, which adopted Resolution 48.11, advocating the use of an “international instrument” to curb global tobacco consumption.⁷⁷ Also, “[a] detailed outline of the proposed document . . . setting forth various options for international legal strategy for tobacco control and recommending the development and implementation of a WHO framework convention on tobacco control . . . to promote global cooperation and national action for tobacco control.”⁷⁸ In 1999, Member States finally established both a WHO FCTC Working Group to draft core treaty elements and an Intergovernmental Negotiating Body to develop the treaty text.⁷⁹

The FCTC was designed as a compromise solution between a purely recommendatory instrument and a binding convention. The FCTC established *734 evidence-based provisions for curbing global tobacco consumption, many of which focused on the advertising, labeling, marketing, packaging and promotion of tobacco products.⁸⁰ The convention has been followed by additional action to enhance and clarify the strength and scope of the treaty.⁸¹ The progress of this action, however, has progressed unevenly. The FCTC's Conference of the Parties (“COP”) quickly adopted implementing guidelines for some of the treaty's mandates, but struggled to adopt others. A protocol on illicit trade in tobacco products languished for years in the COP. Notwithstanding those efforts, the FCTC was adopted by Member States in 2003 and entered into force on February 27, 2005.⁸² One hundred and seventy-eight parties have ratified or acceded to the FCTC as of June 2014.⁸³

C. Proposed Conventions

The somewhat disputed success of the International Code, the IHR and the FCTC have led prominent public health scholars and organizations to call for an increase in the number of issue-areas over which national public health measures may be elevated to international fora and to call for a more comprehensive, global approach to international public health challenges.

1. Framework Convention on Alcohol Control

While modest in comparison to tobacco, the disease burden imposed by alcohol consumption is substantial. Alcohol consumption not only results in greater harm to third parties relative to other drugs like cocaine and heroin,⁸⁴ but also has substantial deleterious effects on users, such as increased risks of cancer and heart disease, traffic accidents, burns, poisonings, and drownings.⁸⁵ Additionally, alcohol consumption facilitates risky *735 sexual behavior, contributing to the spread of HIV/AIDS and other sexually transmitted diseases.⁸⁶

In 2010, the WHO published a report titled “Global Strategy to Reduce the Harmful Use of Alcohol” (the Report)⁸⁷ in which it concluded that “2.5 million people worldwide died of alcohol-related causes in 2004, including 320,000 young people between 15 and 29 years of age.”⁸⁸ WHO recommended a number of interventions consistent with analogous FCTC mandates, including: educating people on the consequences of alcohol abuse; restricting the sale of alcohol to minors; implementing comprehensive marketing restrictions; increasing taxes on alcohol products; and addressing illicit or informally produced alcohol. The Report is not binding; it merely serves as a guide for member nations when adopting their own alcohol control laws. Organizations like the American Public Health Association,⁸⁹ the American Society of Addiction Medicine,⁹⁰ the World Medical Association, as well as leading medical journals advocated an international alcohol control treaty based in significant part on the FCTC and WHO recommendations.⁹¹ Editors of one of these journals, the *Lancet*, have also posed the question as to the desirability of a Framework Convention on Obesity Control based in part on WHO's Global Strategy for Diet, Physical Activity and Health.⁹²

2. Framework Convention on Global Health

Without explicitly criticizing the incrementalism inherent in an issue-by-issue approach to international public health law,⁹³ noted public health scholar and advocate Lawrence Gostin and his collaborators have endorsed a comprehensive approach to meet the “basic survival needs” of all humans through a Framework Convention on Global Health.⁹⁴ Uniting the broad agreement between governments on a human right to health as *736 well as the health-related aspects of the Millennium Development Goals, Gostin argues that a FCGH would address the substandard living conditions in many developing states.⁹⁵ These basic survival needs are sanitation and sewage, pest control, clean air and water, tobacco reduction, diet and nutrition, essential medicines and vaccines, and functioning health systems for the prevention, detection, and mitigation of disease and premature death.⁹⁶ The Framework Convention on Global Health would commit states to certain forms of support for these objectives,⁹⁷ facilitate cooperation and formation of expert communities addressing them, and impose a range of mechanisms to enforce commitments.⁹⁸

Under the current vision of the agreement, WHO would coordinate states' commitment “to a set of targets, both economic and logistic, and [the dismantling of barriers] to constructive engagement by the private and charitable sectors.”⁹⁹ In legal terms, a FCGH could “commit states to specific action . . . targeting the unhealthy conditions that combine with poverty to exacerbate and perpetuate inequality.”¹⁰⁰

The FCGH would be implemented in stages through FCTC-like governance structures including a conference of the parties, secretariat, technical advisory body and representative roles for civil society groups.¹⁰¹ Initially, the FCGH would emphasize capacity building,¹⁰² priority setting, *737 ¹⁰³ engaging stakeholders,¹⁰⁴ activity coordination,¹⁰⁵ and progress evaluation and monitoring.¹⁰⁶

3. Medical Research and Innovation Treaty

Because of the controversial relationship between intellectual property rights, the changing nature of pharmaceutical financing and innovation and access to medicines in developing countries, the World Health Organization has undertaken a series of studies aimed at addressing the failure of a robust IP-rights protection regime to generate the medicines and technologies developing countries need most.¹⁰⁷ Drugs for diseases for which treatments are available

are too expensive because of patents and trademarks, while the diseases for which the market will likely be paltry attract little research and development funding.¹⁰⁸ Helping to address this deficit are efforts coordinated with the World Trade Organization and the World Intellectual Property Organization as well as major international charities. In 2012, the WHO's Consultative Expert Working Group published *Research and Development to Meet Health Needs in Developing Countries: Strengthening Global Financing and Coordination*, in which it called for a binding framework treaty to address innovation and research capacity in developing countries and to design a system to promote development of treatments through incentive and other financing mechanisms.¹⁰⁹

The CEWG's report extensively covered the obstacles strong IP protections pose for addressing medical research and development needs in *738 developing countries. The report squarely addressed existing IP instruments, viewing a medical research and innovation "convention not as a replacement for the existing intellectual property rights system but as a supplementary instrument where the current system does not function" and emphasizing the need for research and development breakthroughs to be developed by other researchers.¹¹⁰ The recommended elements of the proposed treaty suggest the difficulties member states face for attempts to manage IP rights in a health-based treaty. For example, the only element of the proposed treaty that specifically mentions intellectual property reads:

[A global strategy on public health, innovation and intellectual property will] encourage and support the application and management of intellectual property in a manner that maximizes health-related innovation, especially to meet the R&D needs of developing countries, protects public health and promotes access to medicines for all, as well as explore and implement, where appropriate, possible incentive schemes for R&D.

This provision might be read to introduce some modification of the strong IP rights that now characterize multilateral trade as well as bilateral and regional investment treaties. But it also obscures an underlying ambiguity--"managing intellectual property to maximize health-related innovation" might easily accommodate the current views of pharmaceutical patent holders who argue that long periods of exclusive control are precisely the kind of incentive they need to maximize health-related innovation.¹¹¹

D. Public-Private Partnerships

It is in the context of the growing ties between the private and public sectors that public health activists, scholars and organizations refer to the growing importance of "governance" in solving public health problems at the international level, a phrase which wraps together individuals, governments, firms, agencies and charities.¹¹² Indeed, the World Health Organization's Constitution incorporated the role of non-governmental *739 organizations, who by 1948 had undertaken significant efforts toward eradicating infectious diseases and caring for injured and sick persons.¹¹³

The Global Fund, for example, is a public-private partnership dedicated to collecting and allocating resources and funds for "a world free from the burden of AIDS, TB and malaria."¹¹⁴ Each needs-based country has control over its own implementation of measures to prevent the spread of these diseases and is provided funding based on the effectiveness of the measures used.¹¹⁵ Despite pockets of political unpopularity and misuse of money, Global Fund claims to have saved 6.5 million lives since its establishment.¹¹⁶ Three million people have been provided AIDS treatment, over 7.7 million have been treated for TB, and over 160 million insecticide treated bed nets have been distributed.¹¹⁷

Similarly, the Bill and Melinda Gates Foundation, together with WHO, UNICEF, the World Bank and major pharmaceutical firms, established the Global Alliance for Vaccines and Immunizations (“GAVI”). GAVI is funded through the International Finance Facility for Immunization (IFFI), which is itself funded by the governments of Australia, France, Italy, the Netherlands, Norway, South Africa, Spain, Sweden and the United Kingdom.¹¹⁸ Eligible states determine their immunization needs, apply for funding support, and administer approved vaccination programs. Under GAVI's Advance Market Commitment (AMC) program, donors commit funds to guarantee the price of vaccines once they have been developed. In exchange, companies promise to provide the vaccines at an affordable price to developing countries.¹¹⁹

Global Fund and GAVI represent just two examples of public-private partnerships, which number in the hundreds, and health-related NGOs, which number in the tens of thousands.¹²⁰ The participation of major non-^{*740} governmental organizations in global public health is not new, although the innovations current ones are introducing into administration and management are.¹²¹ In some ways, public-private partnerships are better able to balance IP rights with their public health missions, working as they do within the strong patent regimes donors generally enjoy.¹²² Global Fund and GAVI, for example, are theoretically able to manage a range of supplier behaviors through their contracts.¹²³

II. THE EXPANSION OF INTELLECTUAL PROPERTY RIGHTS IN TRADE AND INVESTMENT TREATIES

With the exception of public-private partnerships, the international coordination agreements outlined above are dependent on traditional notions of treaty compliance including reciprocity, transparency, legitimacy, mobilization and vertical integration (i.e., international rules and standards are internalized into national law).¹²⁴ There are weak or no enforcement mechanisms to speak of, the benefits of coordination and mobilization serving as their own justifications. Whatever the strengths of these justifications, they are threatened by a nearly perfect parallel development in international law: international intellectual property protection. Yet unlike the enforcement mechanisms embedded in international public health law instruments, intellectual property rights holders enjoy, almost uniformly, enforceable rights in these international agreements, even when they conflict with public health measures.

These agreements range from the protections given intellectual property rights holders under regional and multilateral trade treaties to the broad scope of legal protections given both “investors” and “investments”^{*741} under bilateral investment treaties. The upshot of these parallel, contradictory legal mechanisms is the frustration of global health law objectives like reduced tobacco use, expanded access to vaccines in the event of pandemic or even the creation of mutual trust necessary for international public health treaties to work. The end result is that robust IP protection that accompanies trade liberalization works in persistent opposition to public health objectives.¹²⁵

A. *The 1883 Paris Convention for the Protection of Industrial Property*

Contemporaneously with late nineteenth century efforts to establish the first international public health law treaties, a small group of states sought to protect their citizens' industrial and intellectual property as they moved across borders.¹²⁶ Disparate national patent and trademark regimes meant that rights holders in one state might lose patent or trademark protection in another if they did not simultaneously file for protection in all relevant states.¹²⁷ Like public health law, intellectual property law was essentially national in nature, though growing international trade mobilized efforts toward an international approach to legal barriers for IP. The Paris Convention for the Protection of Industrial Property created a legal union between participating states in which foreign industrial design, patent and trademark applications received

the same treatment as national applications; covered intellectual property first protected in one state received priority in other participating states; and codified some common substantive protections.¹²⁸ The treaty also specifically addressed forms of unfair competition not related to patents or trademarks, provisions that were subsequently strengthened when the parties revised the treaty in several conferences from 1886 to 1967.¹²⁹ Membership in the treaty grew from 11 parties in 1883 to 174 in 2013.

*742 While the treaty never specifically addressed the relationship between international intellectual property protection and public health, it did create exceptions that foreshadowed the principal conflicts occurring between 1994 and 2012. Compulsory licenses were always contemplated for public health reasons, while the addition of Article 6quinquies(B)(iii) in 1934 allowed the denial of registration or the invalidation of trademarks that might mislead consumers.¹³⁰ In short, the Paris Convention, later incorporated into the WTO's TRIPS Agreement, provided broad exceptions for the compulsory licensing of patents related to medicines and prohibited trademarks that might create false impressions as to products' health-related attributes.¹³¹

Like public health treaties originating at the same time, the Paris Convention tended to suffer from underenforcement as well as the absence of a specific forum to which an aggrieved IP rights holder might resort. Compliance and complaints were largely diplomatic matters.¹³² For example, the international organization created to administer the Paris Convention and, later, the Berne Convention for the Protection of Literary and Artistic Works-- the United International Bureaux for the Protection of Intellectual Property ("BIRPI," its French acronym¹³³)--never enjoyed more than a formal coordinating role and was, strictly speaking, an arm of the Swiss government.¹³⁴

From 1893 to 1967, BIRPI oversaw revisions to the major treaties including the ways in which the agreements would govern new technologies; entry by newly independent former colonies; and increasing efforts to include substantive law in the treaties.¹³⁵ In 1967, the parties agreed to transform BIRPI into an international organization, the World Intellectual Property Organization ("WIPO"), which operated formally from 1970 and as a specialized agency of the United Nations from 1974. WIPO has largely overseen the growing body of IPR harmonization and substantive law treaties like the Patent Cooperation Treaty, the Trademark Law Treaty and the (slowly forming) Substantive Patent Law Treaty. It is funded largely through fees paid by private users of the treaties it develops.¹³⁶ *743 Because WIPO became a specialized agency of the United Nations in the same period that developing and newly independent states were pressing for a New International Economic Order, it never fully served the interests of strong international intellectual property protections.¹³⁷

B. International Trade Law

International intellectual property law became decidedly more influential when it was not only folded in with the international free trade regime, but was equipped with judicial enforcement requirements that gave IP rights holders the capability to enforce those rights in domestic courts and administrative tribunals. Because the Paris Convention and other efforts at international IP protection had failed to satisfy the demands of states with strong IP rights-holding constituencies, individual states had often regulated IP practices through domestic trade statutes.

For example, in the United States, Section 301 of the 1974 Trade Act "authorizes the President to take all appropriate action, including retaliation, to obtain the removal of any act, policy, or practice of a foreign government that violates an international trade agreement or is unjustified, unreasonable, or discriminatory, and that burdens or restricts U.S. commerce." Private IP rights holders were authorized to file 301 petitions, many of which focused on failures to protect

IP rights abroad. In 1988, Congress enhanced Section 301 by requiring the Office of the U.S. Trade Representative to compile “Special 301” Reports which identify countries that do not provide “adequate and effective protection” of intellectual property rights or “fair and equitable market access for persons that rely on intellectual property protection.”¹³⁸

Yet even efforts like these confront diplomatic and political limits. For example, the 2011 Report identified two key U.S. allies, Canada and Israel, as having “serious intellectual property rights deficiencies,” yet resolving those deficiencies is likely to be complicated by other diplomatic, commercial and strategic priorities.¹³⁹ Therefore, from states with powerful IP rights-holding constituencies, the desirability of an agreement that gave automatic rights to enforceability was obvious.

1. The WTO

After the failure of the International Trade Organization to obtain US support during the Truman administration, the less centralized General Agreement on Tariffs and Trade (GATT) became the organizing treaty under which states reduced official or governmental barriers to trade. *744 Through eight rounds of negotiations stretching over more than 40 years, trading states gradually lowered tariffs as well as “non-tariff barriers” to trade like customs procedures, import licensing requirements and export subsidies. The so-called Uruguay Round of GATT negotiations commenced in 1986 and lasted through 1994, when the World Trade Organization was established.

The “World Trade Organization” refers to about 60 agreements, several of which affect participating states' ability to establish and regulate their health systems. The Agreement on Technical Barriers to Trade (TBT) governs potentially trade-restrictive public health regulations while the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) requires that states pass laws providing foreign intellectual-property rights holders with a number of administrative and judicial protections. The Agreement on Sanitary and Phytosanitary Measures (SPS) establishes the principles by which states may regulate food safety. The WTO agreements provide for relatively circumscribed situations in which public health measures may prevail over liberal trading rules.¹⁴⁰

2. TRIPS

TRIPS is by far the most controversial of the WTO agreements with respect to international public health law.¹⁴¹ Unlike the general theory of reducing barriers to trade that justified GATT, TRIPS was theoretically justified by the need to increase legal protections for intellectual property rights holders in order to facilitate the expansion of products, processes, accompanying trademarks, and creative works into new markets.¹⁴²

Many economists agree that in most circumstances, eliminating barriers to trade between nations is net welfare increasing for each nation and for the global economy. Indeed, economists argue that a state should adopt open trade policies even if others do not. As Paul Krugman puts it, “[i]f economists ruled the world, there would be no need for a World Trade Organization. The economist's case for free trade is essentially a unilateral case: a country serves its own interests by pursuing free trade regardless of what other countries may do.”¹⁴³

The issue of the optimal level of intellectual property protection, however, is not so straightforward. Most economists agree that nations should adopt some intellectual property laws, although what the content of these *745 laws should be is a matter of significant disagreement. Intellectual property rules involve distributional issues.¹⁴⁴

TRIPS' approach was to grant patent, copyright and trademark holders rights to certain minimal statutory protections as well as resort to administrative and judicial processes to enforce those rights.¹⁴⁵ Member states may pass protections greater than those detailed in TRIPS¹⁴⁶ but additional protections must be extended to nationals of other member states.¹⁴⁷ In addition to substantive provisions, TRIPS also outlines a comprehensive framework for civil adjudication of IP rights.¹⁴⁸ Member states must create private causes of action¹⁴⁹ as well as remedies including injunctions, money damages, and the use of border restrictions.¹⁵⁰ States must also give IP rights holders access to judicial review of all administrative decisions concerning their IP laws.¹⁵¹

Prior to the Uruguay Round, the trade liberalization negotiation process had been largely driven by the trade agenda of developed states; agriculture was for the most part excluded and the important bargains were struck between the industrialized countries.¹⁵² The Uruguay Round, by contrast, involved a greater range of issues, many of which were long-standing priorities of developing states. Their interests in lowering barriers to trade in agricultural goods, clothes and textiles resulted in a “grand bargain” in which they agreed to impose strong monopoly protections for copyrights, trademarks, and, most importantly from the North American, Japanese and European perspective, copyrights and patents.¹⁵³

***746** With respect to the relationship between the international public health law movement and the international intellectual property protection movement, the Uruguay Round decidedly subordinated the former to the latter. Developing states won some flexibility with respect to implementation of TRIPS obligations, most notably through Articles 7 and 8, which respectively emphasized the need for intellectual property rules to allow for development and technology transfer as well as measures necessary to protect public health and nutrition.¹⁵⁴ Article 8 did not provide a general public health exemption from TRIPS implementation but rather conditioned those measures on TRIPS compliance.¹⁵⁵ Meanwhile, Article 31 of TRIPS allows for nonconsensual authorizations of patents--a provision whose importance was elevated by the Doha Declaration on the TRIPS Agreement and Public Health--but requires that those authorizations be accompanied by appellate access to national courts or “direct higher authority.”¹⁵⁶

These protections effectively imparted individually enforceable rights to IP rights holders. Jerome Reichmann detailed how strong these rights may be: “[Developed countries] expect developing countries to implement [their] obligations concerning domestic, judicial and administrative enforcement of foreigners' intellectual property rights, including detailed provisions governing the discovery of evidence, rights to counsel, injunctions, damages and temporary restraining orders. These provisions mean business.”¹⁵⁷ States Parties are not required to allocate more resources toward enforcement of IP rights than “law in general,” so many individual IP rights-holders may not see a sufficient payoff to invest resources in pursuing individual civil actions to vindicate property rights. But the economic sectors most closely tied to human health--food, tobacco, alcohol and pharmaceuticals--are precisely those in which IP rights holders are most likely to try to preserve substantial investments in advertising, research and development.¹⁵⁸

3. SPS and TBT Agreements

Relatedly, measures affecting the labeling of food or beverage containers may not only be challenged on the grounds that they affect trademarks on packaging and labeling, but also as trade-restrictive regulations under the SPS and TBT agreements. These agreements do not apply to ***747** intellectual property rights per se but may, together with IP rights claims, cumulatively weigh against public health interventions. The SPS Agreement authorizes states to adopt “sanitary and phytosanitary” measures to ensure the safety of food and the prevention of imported pests and diseases, but limits

the trade restrictiveness of those measures and encourages the use of internationally accepted standards like those issued by the Codex Alimentarius Commission (“Codex”).¹⁵⁹ Empowering Codex standards for their WTO relevance has correspondingly pressured decisions toward their free trade compatibility. Emily Lee has detailed this process in the following way:

The standard-setting process seems to present a unique “democratic” setting in which industry representatives, government officials, and NGOs can negotiate and forge a unified position, but in practice, the distribution of influence is weighted heavily to reflect industry concerns. The composition of national delegations in Codex meetings increasingly reflects the commercial importance of Codex decisions, as does the increasing difficulty in the negotiation of general principles for the elaboration of standards. Also, “Proceedings of the Commission often have turned into trade battlegrounds and forums for deregulation where decisions tend to reflect political compromises designed to promote international trade at the expense of human health.”¹⁶⁰

European Union officials, for example, argued in 1994 that U.S. nutrition labels restricted trade.¹⁶¹

Similarly, the TBT Agreement encourages states to base regulatory measures on international standards when available and appropriate. The easiest way to accomplish this is by adopting an accepted international ***748** standard like those issued by the International Standards Organization (“ISO”). However, the process by which those standards are developed are not only opaque, but are dominated by the industries affected by the standards issued. The tobacco industry, for example, used the ISO standard for low-tar labeling as part of its broader effort to convince the public that a “safer” cigarette existed.¹⁶²

4. The Anti-Counterfeiting Trade Agreement

The Anti-Counterfeiting Trade Agreement (“ACTA”)¹⁶³ represents the codification of principles advanced in a number of initiatives undertaken by developed states to enhance protections for intellectual property holders beyond what TRIPS achieved.¹⁶⁴ According to the U.S. Trade Representative, “the goal [of ACTA] is to set a new, higher benchmark for enforcement that countries can join on a voluntary basis. . . . ACTA will include commitments in three areas: (1) strengthening international cooperation, (2) improving enforcement practices, and (3) providing a strong legal framework for IPR enforcement.”¹⁶⁵ After eleven rounds of negotiations, the final ACTA text was adopted¹⁶⁶ in May 2011.¹⁶⁷

***749** Originally aiming to combat the counterfeiting of goods and piracy in international markets, ACTA contains increased criminal sanctions for IPRs infringement and stronger border measures¹⁶⁸ to target illegal trafficking in infringing goods through customs processes.¹⁶⁹ ACTA requires, under each Party's available laws, “enforcement procedures . . . to permit effective action against any act of infringement of intellectual property rights covered by this Agreement.”¹⁷⁰ While commentators have detailed criticisms of those measures specifically (especially border controls), this section will focus on ACTA's civil enforcement provisions.¹⁷¹

Under ACTA, “[e]ach Party shall make available to right holders civil judicial procedures concerning the enforcement of any [IPR].”¹⁷² Among those procedures are injunctions,¹⁷³ damages,¹⁷⁴ other remedies,¹⁷⁵ and the collection and

preservation of evidence.¹⁷⁶ These civil enforcement provisions are not limited to first-party infringers. “Each Party shall provide that, in civil judicial proceedings concerning the enforcement of intellectual property rights, its judicial authorities shall have the authority to order against a party to desist from infringement an order to that party or where appropriate to a third party over whom the relevant judicial authority exercises jurisdiction . . . to prevent infringing goods from entering the channels of commerce.”

ACTA represents a new restructuring of civil enforcement to increase the rights of IP holders, with potentially deleterious effects on access to medicines.¹⁷⁷ For example, because ACTA requires that judicial authorities *750 have the power to issue injunctions against third parties, any intermediary provider of generic medicines to developing countries potentially faces liability under the ACTA regime.¹⁷⁸ According to Brook Baker

In the context of access to medicines, the concept “intermediary services” may be quite ominous. Services are obviously provided by ISPs - allowing supplier to market medicines online - and in the pharmaceutical context, by shipping agents Perhaps more ominously, many others who helped fund or facilitate purchases of generic drugs, as they moved through the stream of international commerce from producer to consumer could face intermediary liability. For example, the Global Fund solicits and funds country-led proposals for funding priority disease prevention, treatment, and care.¹⁷⁹

ACTA-compliant laws may enable foreign rights holders to target local industries through threats or the use of litigation.¹⁸⁰ The force of the agreement extends beyond its power to shape domestic law, as it will inevitably also form the template for future bilateral agreements between ACTA and non-ACTA states.¹⁸¹ The Trans-Pacific Strategic Economic Partnership Agreement (“TPPA”) mimics many of ACTA's IP provisions, although its conclusion is more distant.¹⁸²

C. Bilateral and Regional Trade and Investment Treaties

More common than broad, multilateral trade instruments like TRIPS and ACTA, bilateral and regional investment and trade agreements contain some of the strongest protections for intellectual property.¹⁸³ Bilateral investment treaties (“BITs”), for example, take a number of forms and include provisions authorizing IP rights-holders to vindicate claims in national or international courts or dispute resolution fora. Generally, BITs are negotiated between developed and developing states.¹⁸⁴ BITs contain *751 provisions guaranteeing investors from one state protections for their investments in the other state; these protections often define IP rights in broad terms. These guarantees may include fair and equitable or non-discriminatory treatment,¹⁸⁵ free transfer of profits and currency, and, in many cases, payment of compensation should a host state adopt measures having the effect of direct or indirect expropriation.¹⁸⁶ The origin and number of BITs in existence is well-documented, although the reasons for their proliferation remain in dispute.¹⁸⁷ At the end of the 1980s, records at the U.N. Conference on Trade and Development showed 385 BITs; a decade later, the number reached 1,857.¹⁸⁸ Current estimates show approximately 3,000 BITs in force.¹⁸⁹

BITs do not, typically, include enumerated rights for contracting states outside their ability to prohibit certain economic activities altogether, exempt certain economic sectors from the treaty's applicability or to take normal regulatory action in the interest of national security, public order, public health or public morality--so-called “non-precluded measures.”¹⁹⁰

Contracting states are still potentially obligated to compensate investors for these “regulatory takings.” Public health exceptions, for example, are often phrased in vague ways in the preamble, undermining their use as a defense to an investor claim.¹⁹¹ Most of these treaties provide investors access to one of the major international arbitral tribunals to vindicate rights under a BIT.¹⁹²

These treaties often give much stronger protection, with fewer standard exceptions, to intellectual property rights than international IP agreements, TRIPS or domestic law. For example, the Swiss-Uruguayan BIT protects as investments “copyrights, industrial property rights (such as patents of inventions, utility models, industrial designs or models, trade or *752 service marks, trade names, indications of source or appellation of origin), know-how and good-will” and requires the counterparty to compensate an investor for “measures [taken directly or indirectly] of expropriation, nationalization or any other measure having the same nature or the same effect.”¹⁹³ Under the 2012 U.S. Model BIT, an “investment” means every asset that an investor owns or controls, directly or indirectly . . . includ[[ing] . . . intellectual property rights.” IP rights are accorded similar rights as though they were real property like land or a manufacturing facility, the traditional covered investments, although the U.S. Model BIT creates an explicit nexus between rights to compensation and measures consistent with TRIPS.¹⁹⁴

Indeed, if TRIPS represented the ceiling of substantive IP rights and accompanying enforcement agreements, the entire debate on the balance between TRIPS and public health might focus on flexibilities available in the language of the agreement.¹⁹⁵ But the flexibilities that WTO member states might enjoy under TRIPS are narrowed, sometimes drastically, in bilateral investment and trade treaties. For example, the U.S.-Jordan Free Trade Agreement includes limitations on compulsory licenses and parallel imports. The costliest TRIPS-plus terms are those that impose “data exclusivity” separate from patent protection. Under “data exclusivity” regimes, a generic drug manufacturer is not allowed to use clinical and safety trial data from the initial drug application. This essentially requires the generics applicant to undertake prohibitively expensive clinical trials, and imposes on the government or end user the cost that generics theoretically exist to save. As Oxfam indicates:

These expenditures have required that both public health system and individuals pay higher prices for many new medicines that are needed to treat serious non-communicable diseases (NCDs), such as hypertension, asthma, diabetes, and mental illness. For example, new medicines to treat diabetes and heart disease cost anywhere from two to six times more in Jordan than in Egypt, where there are no TRIPS-plus barriers.¹⁹⁶

Similar conflicts have arisen over alcohol, food and tobacco regulation. When Uruguay introduced measures restricting the images, colors, words and phrases that could appear on cigarette packages, Phillip Morris International's Swiss subsidiaries challenged the constitutionality of the *753 regulations under Uruguayan law.¹⁹⁷ PMI failed in the Uruguayan courts before ultimately availing itself of a bilateral investment treaty between Switzerland and Uruguay which not only gave PMI's trademarks much stronger protections than under either international trade or Uruguayan law, but also placed significant limitations on the Uruguayan courts to serve as the final authority on the dispute.¹⁹⁸

III. CONFRONTATIONS BETWEEN IP RIGHTS AND INTERNATIONAL PUBLIC HEALTH LAW

As international public health law and international intellectual property law have strengthened, so have the conflicts anticipated by each movement's advocates. Between 1994 and 2012, the conflict between international intellectual property rights and international public health law confronted parties to each of the major agreements outlined above

and foreshadowed conflicts that would arise during the negotiation of potential agreements under instruments like the Medical Research and Innovation Treaty, the Framework Convention on Alcohol Control and the Framework Convention on Global Health. As the discussion of these episodes shows, international public health law exercised little normative force over strong intellectual property rights. Instead, international public health law norms prevailed most often when sponsored by a strong middle income states like Brazil, India, South Africa or Thailand.¹⁹⁹

A. Guatemala, Brazil, India, the Philippines and the 1981 WHO Code on the Marketing of Breastmilk Substitutes

Guatemala represents precisely the kind of state for which the 1981 WHO Code on the Marketing of Breastmilk Substitutes was intended. Its “infant mortality rate is 55 per 1,000 live births and the maternal mortality rate is 110 per 100,000 live births.”²⁰⁰ Also, “approximately 16 percent of infants suffer from low birth weight, and approximately 50 percent of all children are malnourished.”²⁰¹

*754 In 1983, Guatemala adopted Law 66-83, Law on the Protection of Breastfeeding, which codified many aspects of the WHO International Code, and in 1987 the Ministry of Health implemented the law through Governmental Order No. 847-87. In 1992, Gerber applied to introduce a new “step-by-step” product line in Guatemala and requested that the products be registered with the Food & Drugs Registration and Control Division, Guatemala's equivalent of the United States' FDA. The FDRC required that Gerber remove its trademarked infant image, include a notice that “breastmilk is the best for baby” as required under the law and further specify the age of the child for which the products were intended.

Gerber pursued a three-prong strategy in response: asserting the products were “complementary” foods under Guatemalan law and therefore not covered by 66-83 and 841-87; bringing a statutory action under U.S. law to eliminate Guatemala's trading preferences for effectively “nationalizing” its trademark; and threatening Guatemala's compliance with (still pending) TRIPS provisions. Gerber argued that:

Article 15 of [TRIPS] states that “The nature of the goods or services to which a trademark is to be applied shall in no case form an obstacle to registration of the trademark.” In addition, Article 20 of the proposed agreement provides in relevant part that “[t]he use of a trademark in the course of trade shall not be unjustifiably encumbered by special requirements, such as . . . use in a special form or use in a manner detrimental to its capability to distinguish the goods”²⁰²

Applying a strained interpretation of “complementary foods,” the Guatemalan Supreme Court of Justice determined that 66-83 and 841-87 applied only to locally prepared foods, not imported goods. Without explicitly acknowledging the role that the trade-based agreements played in their construction of the law, “the case . . . shows . . . that raising the spectre of the new WTO can be an effective pressure tool against small countries that want to implement strong health regulations that may also have negative impacts on commercial interests.”²⁰³

The Pharmaceutical and Health Care Association of the Philippines successfully delayed and then earned relief from comprehensive labeling restrictions through similar arguments, based in part on the trade-restrictive effect of warnings on formula containers.²⁰⁴

*755 Brazil, by contrast, fully incorporated the Code into law in 1988, embedded subsequent WHA resolutions into administrative regulations, and authorized third-party monitoring. Breastfeeding rates have risen steadily as a result.²⁰⁵ Like Guatemala's law, Brazil prohibited infant images on breastmilk substitute packaging. When Gerber entered the Brazilian market, it accepted the prohibition on its infant image. Similarly, in India, where the Infant Milk Substitutes Act adopted a prohibition on images of infants, women, or "phrases designed to increase the saleability of infant milk substitutes or infant food," exclusive breastfeeding at 4-5 months of age is 46%, three times that of the Philippines.²⁰⁶

B. Brazil, India, South Africa, Thailand and Access to Medicines

Access to medicines was a principal concern of developing states during the TRIPS negotiations. Many developing states considered the high prices that accompanied patented medicines and their production processes to frustrate their constitutional and international human rights obligations to provide affordable health care to their citizens.

1. Compulsory Licenses and Parallel Imports

In addition to the generally worded provisions in Articles 7 and 8, TRIPS also includes a compulsory licensing regime under which member states may authorize third-party firms to manufacture patented products or use patented processes.²⁰⁷ Article 31 obligates states to negotiate with patent holders over the terms of these licenses unless they involve a "case of a national emergency or other circumstances of extreme urgency."²⁰⁸ TRIPS does not explicitly address parallel import policies, which are used to purchase patented drugs from a third state where a lower price is charged.

Beginning with South Africa's experience with parallel imports in 1997, Brazil, India, South Africa and Thailand have not only led the way in using these alternatives to expand access to medicines for their own citizens, but have also helped to obtain collective gains for developing countries generally. The confrontation between South Africa and Western pharmaceutical firms, paralleled by Brazil's compulsory license regime for AIDS drugs, achieved at least two key victories. First, sponsoring governments withdrew opposition to compulsory licensing for HIV medications. Second, the episodes prompted states to revisit the TRIPS agreement in light of outbreaks and the reemergence of infectious diseases with disproportionate effects in developing countries. The 2001 Doha Declaration on *756 the TRIPS Agreement on Public Health emphasized the importance of compulsory licenses for HIV/AIDS, tuberculosis, malaria and other epidemics and affirmed the freedom for states to establish their own regimes for parallel imports.²⁰⁹ The final text was ultimately negotiated between the U.S. and Brazil, the former broadly representing states with strong IP rights holding constituencies, the latter representing developing countries pressing for wider access to affordable medications.²¹⁰

In 2007, Thailand expanded the use of compulsory licenses beyond the communicable diseases specified in the Doha Declaration, granting a compulsory license for the heart disease medication marketed as Plavix. Thailand also issued compulsory licenses for four cancer drugs, the disease burden of which is heavier than HIV/AIDS.²¹¹ Indeed, "[f]rom the Thai government's point of view, cancer 'is no less serious than HIV/AIDS.'"²¹² Similarly, in 2012 India granted a compulsory license for kidney and liver cancer medications.²¹³ Indeed, since 1995 "[m]ore than half the compulsory licensing episodes occurred in upper-middle-income countries (including Brazil and Thailand)."²¹⁴

These episodes might be equally construed as protecting powerful domestic industries (e.g. India's generics firms)²¹⁵ rather than exhibiting any form of solidarity these states feel with the plight of developing countries facing large disease

burdens.²¹⁶ That is the point. It may not be norm creation *757 or force flowing from the Doha Declaration that has resulted in compulsory license activity, but rather the political and economic strength of the licensing states that has allowed wider access to affordable medicine, even as international intellectual property protections become stronger and more widespread.

2. TRIPS Flexibilities and Model Laws

Compulsory licenses and parallel imports are relatively drastic actions to narrow otherwise strong patent rights. But states also have a number of other ways in which strong intellectual property rights called for in TRIPS can be diminished. For example, states are under no obligation to allocate greater resources to criminal enforcement of IP rights. If a state restricts the use of its criminal prosecution priorities to non-IP matters, IP rights holders must rely on the civil justice system to vindicate their rights. Although, as noted above, this flexibility may not deter patent and trademark holders in the areas most closely related to health.

States are also free to establish their own standards for patentability, including novelty, non-obviousness and utility.²¹⁷ For example, India passed a patent protection statute that presumptively meets the minimum requirements of TRIPS, granting 20-year exclusivity, for example, but defining “novelty” and “efficacy” in ways that prevent firms from “evergreening” their patents by filing patent applications with marginally different applications or modalities from the protected patents.²¹⁸ Novartis, which had attempted to extend the patent on its cancer treatment drug Gleevec, lost in India's trial courts on even establishing the grounds for a new patent. India's Intellectual Property Appellate Board (which had assumed jurisdiction over patents as a result of TRIPS) determined that it had in fact met the basic requirements of patentability but failed scrutiny under a more specific provision of India's patent act, which erected a high barrier for drug efficacy. The Supreme Court of India affirmed the IPAB's decision that the patent failed India's criteria for novelty.²¹⁹

Section 3(d) of India's Patent Act, which limits the possibility of evergreening patents, is in the process of being replicated in the Philippines, *758 while other developing nations are also likely to use that section as a model.²²⁰ Furthermore, Brazil's compulsory licensing scheme for AIDS drugs has served as model for other Latin American jurisdictions.²²¹ In addition, Brazil used its economic power to negotiate bargains on behalf of Latin American governments seeking lower prices for medicines.²²²

3. Action at the World Trade Organization

In 2008 and 2009, Dutch customs authorities seized at least 19 shipments of generic drugs transiting through the Netherlands, 16 of which came from India.²²³ Brazil and India initiated proceedings at the World Trade Organization to challenge the Dutch and European laws under which the seizures were authorized. The states secured a promise from the E.U. in July 2011 to end the seizures, but Dutch authorities seized another 29 cartons of medicine in December 2012 and E.U. negotiators have balked at specifically addressing the border seizures in ongoing negotiations over an E.U.-India Free Trade Agreement.²²⁴ While Brazil and Indian complaints are technically in abeyance as long as the E.U. abides by its agreement, they challenge a wide range of current IP practices in developed states. While larger markets like Brazil, India and Thailand have managed to withstand pressure to include IP-rights strengthening provisions in investment and trade agreements as well as use the international trading system to expand access to medicines, smaller markets, often where the diseases impose higher morbidity and mortality, are buckling under pressure from more powerful countries.

C. Indonesia and the International Health Regulations

The International Health Regulations depend on a number of identification, communication and treatment mechanisms to address potential *759 pandemics. Vaccines, for example, are one of the most important lines of defense against the emergence of pandemics.²²⁵ The development and distribution of vaccines is dependent on patents on “genetic sequences or proteins of the pandemic virus, as well as on novel methods for vaccine production, [and] the actual vaccine,” in addition to chemicals which maximize the number of doses available from a given antigen or virus.²²⁶

Strong patent protections pose at least two related threats to the functionality of the IHR with respect to preventing and controlling epidemics. First, only a few companies have the infrastructure and technology for vaccine development, and these companies are largely located in developed countries.²²⁷ This concentration renders developing states potentially dependent on wealthier states to manufacture and distribute vaccines in sufficient quantities to address their needs in the case of disease outbreaks. Second, the origin of outbreaks, especially influenza, is often in developing states like China, Indonesia and the Middle East. These states must therefore be willing to share disease samples and biological material relevant to risk assessment, risk management, disease research and vaccine development. When firms patent shared samples, vaccines become unaffordable and the willingness to share is undermined.²²⁸

In 2006, Indonesia withheld H5N1 avian flu samples from WHO, undermining efforts to monitor and produce vaccines in response to an avian flu outbreak that rapidly spread worldwide.²²⁹ Indonesia asserted that its decision was a response to an Australian company's development of a vaccine derived from a virus sample Indonesia provided to WHO.²³⁰ The cycle demonstrated the inequities inherent in the global disease surveillance system established by the IHR. As David Fidler observed:

Developing countries provided information and virus samples to the WHO-operated system; pharmaceutical companies in industrialized countries then obtained free access to such samples, exploited them, and patented the resulting products, which the developing countries could not afford.²³¹

*760 Participation by Indonesia is in many ways crucial to the global surveillance system. He continues: “[w]ithout access to Indonesia's influenza strains, global surveillance was jeopardized, as was the refinement of diagnostic reagents and the development of intervention strategies, which depend on the information surveillance provides.”²³²

In 2009, the outbreak of H1N1 influenza in Mexico demonstrated not only that the global surveillance system benefited Western pharmaceutical firms, but also that in the case of a real pandemic, those firms' sponsoring governments could not be relied upon to equitably share vaccines:

Canada awarded its vaccine contract to a Canadian company because it feared that foreign governments might restrict exports to Canada because of vaccine shortages within their territories. The Australian government made it clear to the Australian manufacturer CSL that it must fulfill the government's domestic needs before exporting vaccine to the United States. The United States pledged on September 17, 2009, to donate 10% of its vaccine purchases to WHO, but on October 28, US Secretary of Health and Human Services Kathleen Sebelius stated that the United States would not donate H1N1 vaccine as promised

until all at-risk Americans had access, because production problems had created shortages in the United States.²³³

Despite clear acknowledgment that the 2009 outbreak originated in Mexico and leveled its most significant toll there, Mexico ““had a terrifically difficult time getting access to the pandemic vaccine.””²³⁴

As a result of these episodes, developing countries led by Indonesia pressed both WHO and developed states to conclude an agreement on equitable access to pandemic vaccines. In 2011, the WHO Open-Ended Working Group of Member States on Pandemic Influenza Preparedness (“PIP”) finalized an agreement in which developing countries agreed to routinely share mutating flu virus samples in exchange for options to reserve antiviral medications, real time vaccine production, and/or IP licenses as well as monetary support commitments from vaccine manufacturers. Even at that, the PIP framework was adopted under WHO's Article 23 recommendatory power, not its Article 19 treaty power or its Article 21 regulation-issuing authority. Moreover, the Standard *761 Material Transfer Agreements appended to it are largely deferential to the patent interests of manufacturers.²³⁵

D. Australia, Uruguay and the FCTC

As with the International Code and the IHR, the WHO's Framework Convention on Tobacco Control engenders confrontations with intellectual property rights, primarily trademarks. At least three of the FCTC tobacco-demand reduction provisions involve or potentially involve conflicts with trademarks, especially on packaging and labeling.²³⁶ Indeed, the visual imagery fundamentally tied to trademarks represents a chief investment by tobacco firms, which use visual and written cues to prompt and manipulate demand for tobacco products.²³⁷ Tobacco firms not only introduced “light,” “mild” and “ultra-light” in their brands to suggest to consumers that “light” versions of cigarettes were safer, they adapted label and packaging color schemes to convey that message; for example, “White-and-gold Marlboro Lights will still suggest “lightness” just by the stark contrast to the red, full-strength Marlboros. The powder-blue Camel Lights with their pastel camel will still look milder than the ornery desert-ocher animal on the regular ‘Filters’ pack.”²³⁸

To combat the potential misleading effects of cigarette packaging, Uruguay implemented a number of FCTC-compliant tobacco control measures between 2008 and 2010, including two which addressed the manipulation of packaging and labeling to shape health perceptions of tobacco products. First, the state required that pictorial warnings cover eighty percent of a cigarette pack's surface. Second, Ministry of Health limited the sale of cigarettes to only one variety per brand, the so-called single presentation requirement.²³⁹ This part of the law prevents a firm from selling multiple varieties of cigarette under a single trademark. For example, Philip Morris International (“PMI”), whose most important asset is the Marlboro brand, could no longer sell Marlboro “Reds,” Marlboro “Greens,” and Marlboro “Blues,” which leaves “Marlboros” as its only authorized variety (although it owns or licenses other brands in the Uruguayan *762 market).²⁴⁰ PMI first challenged the regulations in Uruguayan courts, seeking an injunction based in part on Uruguay's revised, TRIPS-compliant trademark law. Unsuccessful in Uruguayan courts, PMI initiated (through entities it controlled) arbitration proceedings under Switzerland's BIT with Uruguay. That treaty included not only broad definitions of “investor” and “investment,” but also established narrow and toothless exceptions for public health regulations and required even laws passed with assurance of due process to compensate an investor for an “indirect” expropriation.²⁴¹ Despite the regulations falling squarely within the measures recommended by the Framework Convention on Tobacco Control (especially the Article 11 guidelines), the Uruguayan government vacillated

on withdrawing or moderating the measures until strong financial and political support emerged from the Bloomberg Family Foundation, the World Health Organization and hundreds of public health NGOs.²⁴²

Even before the FCTC, firms effectively used international trademark law to undermine strong tobacco control measures. In 1992, Australian legislators considered imposing a “plain packaging” regime on cigarette manufacturers.²⁴³ This requirement provided that only the manufacturer's name could appear in standardized black font, and that the remainder of *763 the package must remain an entirely uniform color, except for government-mandated health warnings.²⁴⁴ British American Tobacco argued before the Australian Senate that the Paris Convention for the Protection of Industrial Property and Australian law would require compensation for the value of its cigarette brands.²⁴⁵ The Australian government rejected the proposed regulations.²⁴⁶ The Ministry of Health announced that “[u]nfortunately, [the proposal] is just not feasible. . . . We would have to buy the tobacco companies' trademarks, and that would cost us hundreds of millions of dollars.”²⁴⁷ Australia revived its plain packaging plan in 2011 and the government prevailed in the High Court of Australia in 2012. In 2011, PMI initiated arbitration proceedings (again through a wholly-owned entity) against Australia under a BIT in effect between itself and Hong Kong.²⁴⁸ Ukraine quickly requested consultations and the establishment of a dispute settlement panel under the auspices of the WTO, attracting the attention of dozens of states interested in whether or not Australia's plain packaging regime is consistent with TRIPS, the TBT Agreement and/or GATT.²⁴⁹

E. Thailand and Pictorial Warnings on Alcoholic Beverage Containers

In January 2010, Thailand proposed legislation requiring that graphic warning labels cover thirty percent of the surface of beer, wine and spirits containers.²⁵⁰ The subsequent response by international alcoholic beverage firms and their supporting governments mirrors the conflict between strong tobacco packaging and labeling regulations and international intellectual property claims. The minutes from the meeting of the Committee on non-Tariff Barriers to trade notes:

The US representative noted that Clause 3 of the draft regulation precluded US labels from having: “any word or statement that misleads consumers to understand that alcoholic beverages are safe and good for health or contain lower level of harmful substances compared with other alcoholic beverages or contains *764 words or statements that directly or indirectly advertise the alcoholic beverage” to the extent that a registered trademark contained any such description, this vague provision could result in trademarks being prohibited on alcoholic beverage packaging.²⁵¹

Argentina, Australia, Chile, Mexico, the EU, New Zealand, and Switzerland also raised either intellectual property or trade barrier challenges to the proposed regulations.²⁵² In his analysis of alcohol manufacturers' participation in trade and investment treaties, Dr. Donald Zeigler observes parallels between the tobacco companies' intellectual property claims and those that alcohol manufacturers advocate in trade and investment instruments.²⁵³

IV. INTERNATIONAL PUBLIC HEALTH LAW IN A WORLD OF STRONG INTERNATIONAL INTELLECTUAL PROPERTY LAW

It is certainly true that international intellectual property protections do not completely preclude international public health law's potential gains. For example, IP protections pose no obvious barriers to preventing the distribution of free infant formula samples to health care workers, nor to the adoption of prohibitions on smoking in public places. Moreover, there are inchoate efforts in discrete areas of international public health law that are generally unrelated to IP rights, like the international recruitment of health workers.²⁵⁴ Yet, broadly speaking, the potential gains from existing international public health law instruments and those on the horizon are fundamentally tied to the subordination of the wide powers intellectual property holders now hold. In spite of the episodes described above, the central significance of international intellectual property protection to the development of international public health law appears curiously askew of global health advocates' primary agenda.

Article 15 of the Framework Convention on Tobacco Control, for example, calls for the elimination of all forms of illicit trade in tobacco products, of which counterfeit cigarettes are an integral part. When the parties negotiated a separate treaty to give effect to that provision, the Protocol to Eliminate Illicit Trade in Tobacco Products, they agreed in Article 2 that “[n]othing in this Protocol shall affect the rights and obligations of any Party pursuant to any other international convention, treaty or international *765 agreement in force for that Party that it deems to be more conducive to the achievement of the elimination of illicit trade in tobacco products.”²⁵⁵ In short, any agreement that gives strong protection to tobacco trademarks, which are always asserted as a defense against the counterfeit cigarette trade, is fully compatible with the Protocol.²⁵⁶

Similarly, at the same time the WHO is attempting to conclude a Medical Research and Innovation Treaty, it is also undertaking greater efforts toward fostering collaboration on counterfeit medicines and devices, i.e., unsafe, unregulated, or fraudulently labeled or represented drugs which pose risks of illness, injury or death to patients. There are of course numerous ways to define “counterfeit” drugs, including a definition that emphasizes the infringement of protected trademarks under TRIPS,²⁵⁷ but also one that focuses on the effects of counterfeits on patients, in which IP rights are less implicated.²⁵⁸ Notwithstanding key policy flexibilities attached to definitional choices, the World Health Assembly has decided to study the public health effects of counterfeit medicines “excluding trade and intellectual property considerations,” a determination which will inevitably influence the outcome of any international agreement on the issue.²⁵⁹

Those calling for a Framework Convention on Alcohol Control have argued rather loosely that it should be another version of the FCTC, and have advanced few if any provisions which might address the IP challenges the FCTC has faced. The WHO's Global Strategy to Reduce the Harmful Use of Alcohol acknowledges the role of marketing in influencing consumption but does not address the role of trademark law in obstructing recommended measures. The Framework Convention on Global Health has gone even further, suggesting that “an FCGH could require states and international organizations to show that loan conditions or trade rules are *766 not detrimental to the public's health.”²⁶⁰ But the FCGH still avoids the detailed international IP protections that would jeopardize its mission.²⁶¹

A. Rescission of Existing Bilateral, Regional and Multilateral Intellectual Property Agreements

Whatever the promise of health diplomacy, it does not appear that “health” is overcoming the traditional concerns of “diplomacy.” Implausible proposals call for the elimination of international IP agreements altogether to solve this problem. Some, like Kojo Yelpalla, would simply throw entire agreements like TRIPS out:

Before TRIPS, over forty countries offered no patent protection for pharmaceutical inventions. Such sovereign authority of states has been compromised by TRIPS as part of the WTO system of agreements. . . .

This exploitation of the inequalities of bargaining power was undertaken at a time when many developing countries were ill equipped or unprepared to appreciate all the implications of TRIPS. Nor did they fully understand the significance of the converging forces at work. In riding the tidal wave of these forces, the developed countries did not merely succeed in linking the right to trade to the protection of intellectual property rights; they also succeeded in setting up a structure whereby, under international law, foreign private interests could subvert the political authority and public interest of the state. . . . It is now widely acknowledged by most observers that TRIPS is a serious threat to human health security.²⁶²

Even scholars less hostile to the underlying purpose of the agreement concede that the built-in flexibilities of TRIPS²⁶³ may not help much against determined IP-rights holders with the heaviest investments in knowledge-intensive processes or assets.²⁶⁴ Yet it is certainly true that in response to developments in international investment and trade law, some states are revising or withdrawing from agreements with strong intellectual property protections.²⁶⁵

***767 B. Revision of Existing Bilateral, Regional and Multilateral Intellectual Property Agreements**

Other, more pragmatic, solutions require working within existing international IP agreement frameworks. Bilateral, regional and international IP treaties, for example, do not need to afford IP holders an entire administrative and judicial framework that may, and often does, exaggerate the benefits those goods offer. Firms, for example, have shown themselves able to punish governments who threaten their intellectual property investments.²⁶⁶ Other solutions involve explicit limitations on the adjudicatory rights private parties enjoy under bilateral or multilateral instruments.²⁶⁷ This is, in effect, the aim of the Doha Declaration, which emphasizes the rights of governments to facilitate access to medicines for their citizens, as well as more modern trends in bilateral investment treaties.²⁶⁸ The United States, for example, has determined that investment agreements should not provide foreign investors with greater substantive protections than domestic investors.²⁶⁹ Australia has recently moved away from investor-state dispute resolutions in its investment agreements.²⁷⁰ Other possibilities include concrete exceptions for public health measures and the exemption of IP and related rights from bilateral agreements.

Another strategy is to explicitly address international intellectual property rights in international public health agreements themselves. WHO Article 19 treaties, like the FCTC and its Illicit Trade Protocol, Article 21 measures like the IHR, and even Article 23 recommendations like the International Code frankly depend on the curtailment or at least contextualization of IP rights to succeed. Ignoring or downplaying the importance of IP rights leaves large gaps in the potential coverage offered by international public health law. To phrase it another way, international public health law to a significant extent is intellectual property law. To be ***768** sure, IP issues often permeate negotiations over international public health law instruments. Negotiators successfully included “trademark” as a subject of FCTC Article 11's prohibition on misleading descriptors over the objection of states with strong trademark-rights holding constituencies.²⁷¹ But the examples described above, including the Illicit Trade Protocol, the Framework Convention on Alcohol Control and the Framework Convention on Global Health demonstrate the general reluctance of public health stakeholders to specifically address management of IP rights as part of broader international public health law initiatives.

This is unsustainable even for public-private partnerships, which generally operate well within the boundaries of international intellectual property protection. The Global Fund's activities, for example, may fall afoul of ACTA.²⁷² The GAVI Alliance's model of Advanced Market Commitment institutionalizes the fundamental difficulty IP rights

pose: because the AMCs are so expensive and technically detailed, they both limit the amount of vaccines that can be purchased and threaten to crowd out lower-cost manufacturers.²⁷³

Strategies incorporating IP law into the global public health framework do not necessarily need to sharply limit or manage IP rights in the text of agreements. However, they must at least address the fundamental threat that enforceable IP rights in international agreements pose to public health interventions. These threats, of course, vary in their severity. For patents, for example, there is an identifiable point of protection at which original innovation is encouraged and therefore welfare-enhancing. Past that point, the patent monopoly threatens accompanying innovations, which may result in higher-quality products or processes or means by which those products or processes might be less expensively distributed. For trademarks, especially alcohol, beverage, food and tobacco trademarks, rights-holders spend vast amounts learning which shapes, colors, figures and other visual cues will enhance consumption. This leads to consumption well beyond any limit set by evidence-based nutrition policy or even the limited purpose trademarks are meant to serve: distinguishing competitors' products or services.²⁷⁴

For example, it makes sense to impose liability upon tobacco manufacturers with respect to the costs deceptive trademarks impose on society and the heavy investments they make in shaping the perception of their products' risks. That liability may be imposed without violating trademark-protective *769 terms in TRIPS and many bilateral investment treaties. This was originally possible under early versions of Article 19 of the FCTC, although the scope of such liability was eventually narrowed. The same would be true, to varying extents, for alcohol and food manufacturers. Together, these three industries account for a significant part of the disease burden that international public health law aims to address.

The Medical Research and Innovation Treaty, to date, represents the approach most likely to harmonize international intellectual property law and international public health law in ways respectful of both. The treaty creates a regime under which specific drug and medical device development will occur in a space “where the current [international intellectual property] system does not function.” The compromises involved will no doubt disappoint both strong IP-rights advocates and public health advocates, but explicitly balancing the costs and benefits of each in an open forum increases the chance that an equitable conclusion will be reached. Indeed, the treaty, once considered dead letter, was revived during the 2013 meeting of the World Health Assembly when the United States proposed a series of demonstration projects that might bridge the current, deep divides between member states over the treaty's terms.²⁷⁵

C. The Role of Multipolarity in Rebalancing International Intellectual Property Protections and International Public Health Law

Addressing intellectual property challenges in public health treaties inevitably means protracted negotiations and perhaps fewer agreements. On the one hand, this might mean advocacy resources are allocated to more effective uses. If the allocation of scarce resources requires a choice, advocates for better access to medicines may do better influencing the scope of patentability in statutory regimes than in negotiating a medical research and innovation treaty.²⁷⁶ On the other hand, the shifting distribution of global political power also increases the opportunities for compromises that may not have existed in 2004 (IHR) or 2005 (FCTC) and certainly did not exist in 1981 (International Code). For example, Brazil and India, which operated largely outside the international trading system in 1981, are now among its most important participants.²⁷⁷ Their thriving *770 generics industries have encouraged both states to use international intellectual property treaties to loosen the strong protections given patents and trademarks in the medicines context.

Similarly, efforts like the putative Framework Convention on Alcohol Control face long odds given that the world's largest alcoholic beverage firms have steep roots not only in North America and Europe but also in Australia, Brazil, Mexico and South Africa. Paula O'Brien has pointed out the inconsistency between Australia's aggressive treatment of tobacco trademarks and the protests it has launched against Thailand's efforts to use the same public health intervention for the alcohol disease burden it bears.²⁷⁸

It is not only individual states and their relative influence that will bear on the potential success of international public health law in the future.²⁷⁹ Brazil, India and South Africa also build coalitions and alliances through direct monetary and non-monetary aid.²⁸⁰ The growing web of economic and political alliances between these and other developing states will expand the possibilities for coalition building in support of certain international instruments but against others.²⁸¹

CONCLUSION

Confrontations between expanding intellectual property rights and international public health law are now poised to increase rather than abate as international agreements addressing both proliferate.²⁸² If the population health gains envisioned by the International Code, the IHR and the FCTC, as well as the Framework Convention on Alcohol Control or the Framework Convention on Global Health are to materialize, their respective advocates must more squarely address the obstacles international property agreements pose for those gains and develop strategies to overcome them or concede their political improbability. These strategies include negotiating concrete public health safe harbors in bilateral investment and trade agreements, modifying dispute resolution mechanisms⁷⁷¹ and conditioning compliance with national law and norms.²⁸³ Other possibilities include ex post strategies that redistribute monopoly gains intellectual property rights holders enjoy. For example, Article 19 of the FCTC might authorize compensation for illness or injury caused by consumption induced by a misleading trademark.²⁸⁴ The proposed Medical Research and Innovation Treaty, for example, places at its core redistributive defects inherent in strong intellectual property regimes. Despite opposition from states with strong patent right holding constituencies, the proposal is, slowly, moving forward. As or more important, the changing distribution of economic, diplomatic and political power renders a broader range of possibilities for coalition building and influence, especially where Brazil, India and South Africa are key stakeholders.²⁸⁵

Footnotes

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- 15 See, e.g., Gregory Schaffer, Michelle Ratton Sanchez & Barbara Rosenberg, The Trials of Winning at the WTO: What Lies Behind Brazil's Success, 41 CORNELL INT'L L.J. 383 (2008).
- 16 See Robert B. Zoellick, The End of the Third World? Modernizing Multilateralism for a Multipolar World, INT'L ECON., Spring 2010, at 40, available at http://www.international-economy.com/TIE_Sp10_Zoellick.pdf (defining the new multipolar world). See also GORDON A. CRAIG & ALEXANDER L. GEORGE, FORCE AND STATECRAFT: DIPLOMATIC PROBLEMS OF OUR TIME 117 (1983); HENRY KISSINGER, DIPLOMACY 23-24 (1997).
- 17 See David P. Fidler, After the Revolution: Global Health Politics in a Time of Economic Crisis and Threatening Future Trends, GLOBAL HEALTH GOVERNANCE 2-3 (2008), http://ghgj.org/Fidler_After%20the%20Revolution.pdf. See generally U.N. Millennium Goals, We Can End Poverty: Millennium Development Goals and Beyond 2015 (last visited Nov. 7, 2014), <http://www.un.org/millenniumgoals/bkgd.shtml> ("The eight Millennium Development Goals (MDGs)--which range from halving extreme poverty to halting the spread of HIV/AIDS and providing universal primary education, all by the target date of 2015--form a blueprint agreed to by all the world's countries and all the world's leading development institutions.").
- 18 See Lawrence O. Gostin & Eric A. Friedman, Towards a Framework Convention on Global Health: A Transformative Agenda for Global Health Justice, 13 YALE J. HEALTH POL'Y L. & ETHICS 1 (2013); Donald W. Zeigler, APHA Approves Framework Convention on Alcohol Control, ALCOHOL, TOBACCO AND OTHER DRUGS (Am. Pub. Health Ass'n), Winter 2007, [hereinafter APHA Report], available at <http://www.apha.org/membergroups/newsletters/sectionnewsletters/alcohol/winter07/alcoholcontrol.htm>. See also JALI: JOINT ACTION AND LEARNING INITIATIVE, HEALTH FOR ALL: JUSTICE FOR ALL--A GLOBAL CAmpaign for a Framework Convention on Global Health (May 2012), available at <http://www.jalihealth.org/documents/manifesto.pdf>.

- 19 International Covenant on Economic, Social and Cultural Rights art. 12(1), Dec. 16, 1966, 993 U.N.T.S. 3. See also Constitution of the World Health Organization, July 22, 1946, 14 U.N.T.S. 185 [hereinafter WHO Constitution] (“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”).
- 20 See Emily Lee, [The World Health Organization's Global Strategy on Diet, Physical Activity, and Health: Turning Strategy Into Action](#), 60 FOOD DRUG L.J. 569, 571 (2005) (“Major noncommunicable diseases (NCDs) (e.g., cardiovascular disease, diabetes, cancers, and obesity-related health conditions) now account for nearly sixty percent of global deaths and almost half (49.5%) of the global burden of disease. Without intervention, NCDs are expected to contribute nearly seventy-five percent of all deaths by the year 2020.”). See also David Byrne, [Is There a Lawyer in the House: The Law of Global Public Health?](#), 33 J.L. MED. & ETHICS 19, 19 (2005) (“In addition, the indirect costs of ill health, such as reduced productivity, are very high. One recent study has calculated the lifetime cost of cardiovascular disease in Germany. Direct healthcare costs are estimated at \$25 billion; indirect costs in productivity are nearly double, at \$48 billion.... One study estimates that the direct and indirect costs of obesity, diabetes, and tobacco each top the \$100 billion mark annually.”).
- 21 See Byrne, *supra* note 20, at 19.
- 22 See David P. Fidler & Lawrence O. Gostin, [The New International Health Regulations: An Historic Development for International Law and Public Health](#), 34 J.L. MED & ETHICS 85, 86-87 (2006) (discussing the old approach compared to the new approach of the IHR).
- 23 Kumanan Wilson, Barbara von Tigerstrom & Christopher McDougall, Protecting Global Health Security through the International Health Regulations: Requirements and Challenges, 179 CAN. MED. ASS'N J. 44, 46 (2008), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464486/>.
- 24 See WHO, WHO REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2008: THE MPOWER PACKAGE 7 (2008), available at http://www.who.int/tobacco/mpower/mpowerreport_full_2008.pdf. See also Allyn L. Taylor, [An International Regulatory Strategy for Global Tobacco Control](#), 21 Yale J. Int'l L. 257, 260-61 (1996). See generally THEODORE H. TULCHINSKY & ELENA A. VARAVIKOVA, THE NEW GLOBAL PUBLIC HEALTH 23 (2d ed. 2009).
- 25 See Gro Harlem Brundtland, Burden of Disease and Best Practices: High-Level Roundtable on Tobacco Control and Development Policy (Feb. 3, 2003), available at <http://www.who.int/dg/speeches/2003/brussels/en/> (discussing how in the coming years many tobacco-related deaths will be in developing countries).
- 26 See Ruger, *supra* note 7, at 436.
- 27 See WHO, DIET, NUTRITION AND THE PREVENTION OF CHRONIC DISEASES: Report of a Joint WHO/FAO Expert Consultation 61-65 (2003), available at http://www.who.int/dietphysicalactivity/publications/trs916/en/gsfao_obesity.pdf (“Almost all countries (high-income and low-income alike) are experiencing an obesity epidemic, although with great variation between and within countries.”). See also David Fidler, [International Law and Global Public Health](#), 48 U. KAN. L. REV. 1, 10 (2000) (“Liberalized trade in certain food products is also thought to contribute to obesity problems in many countries.”).
- 28 See ORGANIZATION FOR ECONOMIC COOPERATION AND DEVELOPMENT [OECD], OBESITY AND THE ECONOMICS OF PREVENTION: FIT NOT FAT 16 (Sept. 23, 2010), available at <http://www.oecd.org/dataoecd/21/19/46004918.pdf>. See also Editorial, The Day of Diabetes: Coming to a Person Near You, 376 THE LANCET 1513 (2010), available at <http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673610620120.pdf> (“Obesity cost the Australian Government Aus\$58•2 billion in 2008, according to Diabetes Australia, which comprised Aus\$8•3 billion of financial costs and Aus\$49•9 billion in lost wellbeing--due to disability or shorter life span.”).
- 29 See Just Balstad Haffield, Harald Siem & John-Arne Rottingen, Global Health Governance: [Examining the Global Health Arena: Strengths and Weaknesses of a Convention Approach to Global Health Challenges](#), 38 J.L. MED. & ETHICS 614, 617 (2010) (“In global health there seems to be a drive towards adopting legally binding instruments, and the examples of recent

international regulations are numerous (e.g., 2006 United Nations Convention on Disabilities, 2005 International Health Regulations [IHR], 2003 WHO Framework Convention on Tobacco Control, Medical Research and Development Treaty [current proposal being discussed as a follow up of the Commission on Intellectual Property Rights, Innovation and Public Health]...). See also David P. Fidler, [The Future of the World Health Organization: What Role for International Law?](#), 31 VAND. J. TRANSNAT'L L. 1079 (1998); Allyn Lise Taylor, [Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health](#), 18 AM. J.L. & MED. 301 (1992).

30 Ruger, *supra* note 7, at 424 (“In its broadest definition, [global health law] includes all international legal regimes relevant to public health--international environmental law, international humanitarian and human rights law, international trade and labor law, international laws relating to arms control, and so on. Construed more narrowly, it incorporates only those international legal regimes specifically designed to address health threats.”).

31 Yet even in that context, the failure of the Biological Weapons Convention to achieve the same enforcement regime strength as the Chemical Weapons Convention is attributed in significant part to the concerns of biological agent manufacturers that monitoring and site inspections may compromise valuable patents and trade secrets. See [The Biological Weapons Convention: Status and Implications: Hearing Before the Subcomm. On Nat'l Security, Veterans Affairs & Int'l Relations of the H. Comm. on Gov't Reform, 106th Cong. \(2000\)](#), available at <http://www.gpo.gov/fdsys/pkg/CHRG-106hhrg74704/pdf/CHRG-106hhrg74704.pdf>. See generally Frank P. Grad, [Public Health Law: Its Form, Function, Future and Ethical Parameters](#), 49 INT'L DIG. HEALTH LEGIS. 19 (1998); David Fidler, [The International Legal Implications of “Non-Lethal” Weapons](#), 21 MICH. J. INT'L L. 51 (1999).

32 See generally Sam Halabi, [Participation and the Right to Health: Lessons from Indonesia](#), 11 HEALTH AND HUMAN RIGHTS 49 (2009).

33 Compare Universal Declaration of Human Rights, G.A. Res. 217(III) A, Art. 25, U.N. Doc. A/RES/217(III) (Dec. 10, 1948), and International Covenant on Economic, Social and Cultural Rights, GA res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) Art. 12, U.N. Doc. A/6316 (1966), with Ruger, *supra* note 7, at 426 (“During this period, appeals to human rights and the right to health in particular have dominated international health discourse, but the human rights movement and the right to health especially have been viewed with considerable skepticism and doubt.”)

34 See Norman Howard-Jones, [The Scientific Background of the International Sanitary Conferences 1851-1938](#) (1975).

35 *Id.*

36 *Id.* at 41.

37 See David . P. Fidler, [The Globalization of Public Health: The First 100 Years of International Health Diplomacy](#), 79 BULL. OF THE WORLD HEALTH ORGANIZATION 842, 845 (2001).

38 Ruger, *supra* note 7, at 426 (“In the early part of the twentieth century, international treaties focused on the control of narcotic drugs and ranged from the 1912 International Opium Convention to treaties dealing with trade in alcohol.”).

39 WHO, [ORIGIN AND DEVELOPMENT OF INTERNATIONAL HEALTH COOPERATION](#) 8 (1991), available at [http://whqlibdoc.who.int/publications/1991/9290211407_\(chp1\).pdf](http://whqlibdoc.who.int/publications/1991/9290211407_(chp1).pdf).

40 WHO, [FIFTY YEARS OF THE WORLD HEALTH ORGANIZATION IN THE WESTERN PACIFIC REGION, 1948-1998: REPORT OF THE REGIONAL DIRECTOR TO THE REGIONAL COMMITTEE for the Western Pacific](#) 10 (1998), available at http://www.wpro.who.int/about/in_brief/RC49_03.pdf.

41 WHO Secretariat, [Review and Approval of the Proposed Amendments to the International Health Regulations](#), 2 A/IHR/IGWG/2/INF.DOC./2 (Jan. 27, 2005), available at http://apps.who.int/gb/gbs/pdf/IHR_IGWG2_ID2-en.pdf. See also Fidler and Gostin, *supra* note 22, at 92 (“Previous transformations in international law's relationship with public health have, over time, atrophied into insignificance. The history of the old IHR tells just such a story. Further, the new IHR's relevance to

some pressing global health problems, such as increasing access to HIV/AIDS treatment in the developing world or stemming the “brain drain” of health workers from developing to developed countries....”).

42 Fidler, *supra* note 27, at 1 (“In the decades since the Second World War, international activities concerning public health carried out by intergovernmental organizations and nongovernmental organizations made little use of international law.”).

43 See George Coddington, Jr., Contributions of the World Health Organization and the International Civil Aviation Organization to the Development of International Law, 59 AM. SOC. INT'L L. PROC. 147, 147 (1965).

44 WHO Constitution, *supra* note 19, at arts. 19, 21.

45 *Id.* art. 22.

46 See Fidler and Gostin, *supra* note 22, at 93 (“For decades, WHO has issued recommendations on many public health problems; but the mixed record of state compliance with WHO guidance should temper enthusiasm for the new IHR's recommendation provisions. The political controversies that surrounded WHO's more aggressive actions during SARS may deter WHO from taking similar actions under the new IHR. Laments about the erosion of global and local public health capabilities suggest that WHO's decades-long effort to improve health conditions in developing countries has also met with only qualified success.”).

47 See Rebecca Katz & Julie Fischer, The Revised International Health Regulations: A Framework for Global Pandemic Response, 3 GLOBAL HEALTH GOVERNANCE, 1, 2 (2010), available at http://blogs.shu.edu/ghg/files/2011/11/Katz-and-Fischer_The-Revised-International-Health-Regulations_Spring-2010.pdf.

48 Ilona Kickbush, Wolfgang Hein & Gaudenz Silberschmidt, [Addressing Global Health Governance Challenges through a new Mechanism: The Proposal for a Committee C of the World Health Assembly](#), 38 J.L. MED. & ETHICS 550, 553 (2010) (“As the United Nations technical agency for health, the WHO has been able to benefit from another form of legitimacy based on knowledge, expertise, and evidence. Meanwhile a wide range of expert organizations in the global arena are also able to provide this type of legitimacy--but they do not have the link to formal legal legitimacy, which allows the WHO to be a normative and standard setting organization.”).

49 Fidler, *supra* note 27, at 15 (“This isolation was not accidental but reflected a particular outlook on the formulation and implementation of international public health policy. WHO operated as if it were not subject to the normal dynamics of the anarchical society; rather, it acted as if it were at the center of a transnational Hippocratic society made up of physicians, medical scientists, and public health experts. The nature and dynamics of this transnational Hippocratic society led WHO to approach international public health without a legal strategy.”).

50 See World Health Assembly [WHA] Res. WHA27.43, (May 23, 1974).

51 Marketing and Promotion of Infant Formula in the Developing Nations, 1978: Hearings Before the Subcomm. on Health and Scientific Research of the Comm. on Human Resources, 95th Cong. 1-2 (1978) (statement of Senator Kennedy).

52 See EMERGENCY NUTRITION NETWORK, HIV, INFANT FEEDING AND THE CODE 4 (May 2002), available at <http://www.enonline.net/pool/files/ife/hiv,-if-and-code.pdf>.

53 See WHO, INTERNATIONAL CODE OF MARKETING OF BREAST MILK SUBSTITUTES 1 (1981) [hereinafter WHO MARKETING CODE], available at http://www.who.int/nutrition/publications/code_english.pdf.

54 *Id.* at 4 n. 2.

55 See WHO, WHA Res. WHA34.22, (May 21, 1981), available at <http://www.ibfanasia.org/WHA/WHA34.22.pdf> (providing the verbatim record of the discussion at the fifteenth plenary meeting).

56 See WHO MARKETING CODE, *supra* note 53, at 10-13.

- 57 See General Comment No. 15 (2013) on the Right of the Child to the Highest Attainable Standard of Health, Comm. on the Rights of the Child, 62d Sess., Jan. 14, 2013--Feb. 1, 2013, P 44, *CRC/C/GC/15* (Apr. 17, 2013). See also Sami Shubber, *The International Code of Marketing Breast-Milk Substitutes*, 36 *DIG. HEALTH LEGIS.* 877, 884 (1985) (indicating that WHA recommendations are not binding but they “carry moral or political weight, as they constitute the judgment on a health issue of the collective membership of the highest international body in the field of health.”).
- 58 U.N. INTERNATIONAL CHILDREN'S EMERGENCY FUND [UNICEF], *INTERNational Code of Marketing of Breast Milk Substitutes* (last updated May 26, 2012), http://www.unicef.org/nutrition/index_24805.html.
- 59 See UNICEF REGIONAL OFFICE FOR WEST AND CENTRAL AFRICA, *PROTECTING BREASTFEEDING IN WEST AND CENTRAL AFRICA: 25 YEARS IMPLEMENTING THE INTERNational Code of Marketing of Breastmilk Substitutes 19 (2007)*, available at http://www.unicef.org/wcaro/WCARO_Pub_Breastfeeding.pdf.
- 60 Revision process of the International Health Regulations (IHR), World Health Organization, www.who.int/ihr/revisionprocess/revision/en (last visited Nov. 7, 2014).
- 61 Katz & Fischer, *supra* note 47 at 2. The threat of the Ebola virus and the emerging HIV/AIDS crisis (among other viruses) were major factors the global community considered when advocating revisions to the existing IHR.
- 62 See David P. Fidler, *Revision of the World Health Organization's International Health Regulations*, *ASIL INSIGHTS* (2004).
- 63 Katz and Fischer, *supra* note 47, at 2.
- 64 The stated purpose is to “prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.” WHO, *INTERNATIONAL HEALTH REGULATIONS (2005) 1* (2d ed. 2005), available at http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf?ua=1.
- 65 Katz & Fischer, *supra* note 47, at 2.
- 66 Fidler and Gostin, *supra* note 22, at 86-87.
- 67 WHO, *International Health Regulations (2005): Toolkit for Implementation in National Legislation*, 1, 7 WHO/HSE/IHR/2009.4 (January, 2009), available at http://www.who.int/ihr/NFP_Toolkit.pdf (“The NFP is a national centre, established or designated by each State Party. The NFP must be accessible at all times for IHR (2005)-related communications with WHO IHR Contact Points.”). As of July 2009, ninety nine percent of all States have established an NFP.
- 68 Katz & Fischer, *supra* note 47, at 2-3.
- 69 *Id.* at 3. Once an incident has been reported, WHO will then “coordinate communications across nations, provide technical assistance to responding nations, and work with international scientific experts to develop recommendations for mitigating the consequences of the event.”
- 70 Fidler and Gostin, *supra* note 22, at 86-87.
- 71 *Id.*, at 92.
- 72 See WHO, *WHA Res. WHA58.3*, art. 43 (May 23, 2005), available at <http://www.who.int/csr/ihr/WHA58-en.pdf>.
- 73 See *id.* art. 56; Fidler & Gostin, *supra* note 22, at 91 (acknowledging the lack of an enforcement mechanism).
- 74 Fidler & Gostin, *supra* note 22, at 91.
- 75 See Sam Foster Halabi, [The World Health Organization's Framework Convention on Tobacco Control: an Analysis of Guidelines Adopted by the Conference of the Parties](#), 39 *GA. J. INT'L & COMP. L.* 121, 129-32 (2010).

- 76 See generally WHO Director-General, *The Feasibility of Developing an International Instrument for Tobacco Control*, EB97/INF.DOC./4 (Nov. 30, 1995) (discussing plans to develop an international instrument for tobacco control and how such an instrument would need to be mutually agreeable to many nations).
- 77 See WHO, *WHA Res. WHA48.11*, (May 12, 1995), available at http://www.who.int/tobacco/framework/wha_eb/wha48_11/en.
- 78 Ruth Roemer, Allyn Taylor, & Jean Lariviere, *Origins of the WHO Framework Convention on Tobacco Control*, 95 AM. J. PUB. HEALTH 936, 937 (2005) available at http://www.eurocare.org/content/download/11981/63683/version/1/file/Origins_ofTMhe+WHO+ FCTC.pdf.
- 79 See Working Group Preceding the Intergovernmental Negotiating Body on the WHO FCTC (1999-2000), *WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL*, http://www.who.int/fctc/about/pre_neg_working_group/en/ (last visited Nov. 7, 2014).
- 80 Halabi, *supra* note 75, at 153-63.
- 81 *Id.* at 162-63.
- 82 See Foreword to *WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL*, at vi (2003) [hereinafter *WHO FCTC*], available at <http://whqlibdoc.who.int/publications/2003/9241591013.pdf?ua=1>.
- 83 Parties to the WHO Framework Convention on Tobacco Control, *WHO FCTC* (Mar. 27 2014, 09:25 CET), available at http://www.who.int/fctc/signatories_parties/en/index.html.
- 84 See David J. Nutt et al., *Drug Harms in the UK: A Multicriteria Decision Analysis*, 376 THE LANCET 1558, 1560-61 (2010). Alcohol consumption and its corresponding negative effects are increasing worldwide. *Alcohol-Related Ills Increasing Worldwide*, U.S. NEWS & WORLD REP. (June 25, 2009), <http://health.usnews.com/health-news/family-health/brain-and-behavior/articles/2009/06/25/alcohol-related-ills-increasing-worldwide>. See also Charles D.H. Parry, *Alcohol Problems in Developing Countries: Challenges for the New Millennium*, 2 SUCHTMED 216, 217-18 (2000), available at <http://www.sahealthinfo.org/admodule/Suchtmed.pdf> (focusing on alcohol problems in developing countries and specifically what needs to be done to reduce the burden of harm in such countries).
- 85 Etienne Krug & Benedetto Saraceno, *Foreword*, in WHO, *ALCOHOL AND INJURIES: Emergency Department Studies in an International Perspective*, at iv (Cheryl J. Cherpitel et al. eds., 2009), available at http://www.who.int/substance_abuse/publications/alcohol/en/.
- 86 Lori A.J. Scott-Shelden et al., *Alcohol Consumption, Drug Use and Condom Use Among STD Clinic Patients*, 70 J. STUD. ON ALCOHOL & DRUGS 762, 762-63 (2009).
- 87 WHO, *GLOBAL STRATEGY TO REDUCE THE HARMFUL USE OF ALCOHOL 3* (2010), available at http://www.who.int/substance_abuse/msbalcstrategy.pdf.
- 88 *Id.* at 5.
- 89 See APHA Report, *supra* note 18.
- 90 See Policy Statement on the Establishment of a Framework Convention on Alcohol Control and the Exclusion of Tobacco and Alcohol from Trade Agreements, *AM. SOC'Y Addiction Med.*, (2007), available at <http://www.asam.org/docs/public-policy-statements/1est-of-framework-convention-4-07.pdf?sfvrsn=0>.
- 91 Allyn L. Taylor & Ibadat S. Dhillon, *An International Legal Strategy for Alcohol Control: Not a Framework Convention--At Least Not Yet*, 108 ADDICTION 450, 450 (2012).

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- 92 See Editorial, Urgently Needed: A Framework Convention for Obesity Control, 378 THE LANCET 741 (2011), available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)61356-1/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61356-1/fulltext).
- 93 See Lawrence O. Gostin et al., Letter to the Editor, A Framework Convention for Obesity Control?, 378 THE LANCET 2049, 2068-69 (2011), available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)61895-3/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61895-3/fulltext).
- 94 A FCGH would “seek innovative solutions for the most pressing health problems facing the world in partnership with non-State actors and civil society, with particular emphasis on the most disadvantaged populations.” Lawrence O. Gostin, [Meeting Basic Survival Needs of the World's Least Healthy People](#), 96 GEO. L.J. 331, 388 (2008).
- 95 See generally Lawrence O. Gostin, [Meeting Basic Survival Needs of the World's Least Healthy People: Toward a Framework Convention on Global Health](#), 96 GEO L.J. 331, 331 (1997), available at http://scholarship.law.georgetown.edu/fac_lectures/11/.
- 96 See Lawrence O. Gostin & Eric A. Friedman, [Towards a Framework Convention on Global Health: A Transformative Agenda for Global Health Justice](#), 13 YALE J. HEALTH POL'Y L. & ETHICS 1, 1 (2013).
- 97 Obligations would include: “[i]ncentives, forms of assistance (for example, financial aid, debt relief, technical support, subsidies, tradable credits), and levels of assistance, with differentiated responsibility for developed, developing, and least developed countries.” Gostin, *supra* note 94, at 388.
- 98 Enforcement tools include: “[i]nducements, sanctions, mediation, and dispute resolution.” *Id.*
- 99 A FCGH would provide several tools to streamline global health policy such as: “[setting standards for] global health spending as a proportion of GNP; defin[able] areas of cost effective investment to meet basic survival needs; build[ing] sustainable health systems; and creat[ing] incentives for scientific innovation.” Gostin, *supra* note 95, at 2.
- 100 Scott Buris & Evan D. Anderson, [A Framework Convention on Global Health: Social Justice Lite, or a Light on Social Justice?](#), 38 J.L. MED. & ETHICS 580, 586 (2010).
- 101 This would facilitate the international community to focus on problems in a “stepwise manner, avoiding potential political bottlenecks over contentious elements.” See Gostin, *supra* note 94, at 388, 389.
- 102 See Gostin & Friedman, *supra* note 96, at 37.
- 103 While well intentioned, many of the charitable donors are simply pouring resources toward health issues that may or may not be the “root” of the problem in a given country. See Gostin, *supra* note 94, at 384-85. Because no single entity has the capacity to solve these issues on their own, “consensus building and communal priority setting are sorely needed.” *Id.* at 385.
- 104 *Id.* at 384. This would enable a wide variety of state and non-state members to pool resources and expertise.
- 105 *Id.* As setting priorities and engaging stakeholders would essentially bring all players to the same page, activity coordination would harmonize the combined efforts.
- 106 *Id.* This would ensure goals being set are met and the promises members make are being kept. *Id.* This is where previous initiatives have failed, as there is no effective follow-up mechanisms for measuring progress. See *id.* at 386.
- 107 See Jack Lerner, [Intellectual Property and Development at WHO and WIPO](#), 34 AM. J.L. & MED. 257, 260 (2008).
- 108 WHO, RESEARCH AND DEVELOPMENT TO MEET HEALTH NEEDS IN DEVELOPING COUNTRIES: STRENGTHENING GLOBAL FINANCING AND COORDINATION 1 (Apr. 2012), available at http://www.who.int/phi/CEWG_Report_5_April_2012.pdf (discussing progress of the Consultative Expert Working Group's work). Multiple theories of intellectual property protection might apply to the same good. For example, a pharmaceutical patent might apply to a given compound, while trademark or trade dress protection might apply to the appearance of a given pill. See Jeremy A.

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Greene & Aaron S. Kesselheim, Why Do the Same Drugs Look Different? Pills, Trade Dress, and Public Health, 365 NEW ENG. J. MED. 83, 83 (2011).

- 109 WHO, *supra* note 108, at 113. The proposed treaty has been variously called the Essential Health and Biomedical R&D Treaty, the Medical Research and Development Treaty, the Biomedical R&D Treaty, etc. *Id.* at 109.
- 110 *Id.* at 122, 147.
- 111 Brian Till, How Drug Companies Keep Medicine Out of Reach, THE ATLANTIC, May 15, 2013, available at <http://www.theatlantic.com/health/archive/2013/05/how-drug-companies-keep-medicine-out-of-reach/275853/>.
- 112 See Kickbush, Hein & Silberschmidt, *supra* note 48, at 559 (“While a government “governs” by using its constitutional powers to pursue specific goals, the term “governance” rather looks at the interactive processes between different actors in the absence of a central authority which lead to a specific outcome. It has frequently been associated with “governance without government,” a view that is increasingly challenged as the role of states in the global governance system is better understood.”). See also Nan D. Hunter, [Risk Governance and Deliberative Democracy in Health Care](#), 97 GEO. L.J. 1, 6 (2008). See generally David Gartner, Beyond the Monopoly of States, 32 U. PENN. J. INT'L L. 595 (2011).
- 113 See WHO Constitution, *supra* note 19, at arts. 69-72.
- 114 World AIDS Day, THEGLOBALFUND.ORG, http://www.theglobalfund.org/en/events/2013-12-01_World_AIDS_Day/ (last visited Nov. 7, 2014).
- 115 Principles, THEGLOBALFUND.ORG, <http://www.theglobalfund.org/en/about/principles/> (last visited Nov. 7, 2014).
- 116 John Heilprin, Fraud Plagues Celebrity-Backed Global Health Fund, HUFFINGTONPOST.COM (Jan. 23, 2011 4:54 PM), http://www.huffingtonpost.com/2011/01/23/global-health-fund-fraud_n_812801.html.
- 117 *Id.* (A Global Fund spokesperson stated that “[w]ithout a spotlight, without investigations, and without some sort of accountability, it's impossible to root out corruption ... [b]ut just simply withdrawing donations, I do believe, would condemn millions of people who are not involved in the corruption to terrible fates.”).
- 118 See Lisa Clarke, [The Responsibility of International Organizations under International Law for the Acts of Global Health Public Private Partnerships](#), 12 CHI. J. INT'L L. 55, 60 (2011).
- 119 See generally Susan Sell, Question for [Global Governance in Intellectual Property and Public Health](#), 77 TEMPLE L. REV. 363, 371 (2004).
- 120 Kickbush, Hein & Silberschmidt, *supra* note 48, at 554 (“The parallels to the dominant position of the Bill & Melinda Gates Foundation today - who in 2007 spent roughly as much on global health as WHO's budget for that year - are obvious.... They now have a significant impact on setting agendas, shaping global health policies and implementing programs. Their sheer number is staggering: a 2007 estimate of AIDS-related NGOs alone counted more than 60,000. More than 200 public-private partnerships are operating in fields such as developing new medicines for neglected diseases, improving access to medical treatment or pooling resources for specific goals.”).
- 121 Lawrence Gostin & Allyn Taylor, Global Health Law: A Definition and Grand Challenges, 1 PUB. HEALTH ETHICS 53, 57 (2008) (“Indeed, a number of modern cutting-edge global health governance initiatives eschew formal international legal regimes, such as the Global Fund, Global Health Security Initiative (GHSI), International Drug Purchase Facility (UNITAID) and International Finance Facility for Immunisation.”).
- 122 Suppliers include bidders, agents, intermediaries, consultants, contractors, affiliates, employees, subcontractors, and agents. THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS, and Malaria, SANCTIONS PROCEDURES RELATING TO THE CODE OF CONDUCT FOR SUPPLIERS 1, available at <http://www.theglobalfund.org/en/documents/governance/> (last visited Nov. 7, 2014).

- 123 See generally *id.*
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- 125 See Kojo Yelapaala, [Quo Vadis WTO? The Threat of TRIPS and the Biodiversity Convention to Human Health and Food Security](#), 30 B.U. INT'L L.J. 55, 85-86 (2012) (“Trade and investment liberalization have produced certain negative externalities in health in developing countries. Trade liberalization has enabled greater availability of highly processed, calorie-rich and nutrient-deprived food in developing countries. Trade liberalization has also opened up the markets of developing countries to other high health-risk products such as tobacco.”).
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- 128 See generally *id.*
- 129 Paris Convention for the Protection of Industrial Property art. 10bis, Mar. 20, 1883, 25 Stat. 1372 [hereinafter Paris Convention], available at http://www.wipo.int/treaties/en/text.jsp?file_id=288514 (prohibiting “(i) all acts of such a nature as to create confusion by any means whatever with the establishment, the goods, or the industrial or commercial activities, of a competitor; (ii) false allegations in the course of trade of such a nature as to discredit the establishment, the goods, or the industrial or commercial activities, of a competitor; (iii) indications or allegations the use of which in the course of trade is liable to mislead the public as to the nature, the manufacturing process, the characteristics, the suitability for their purpose, or the quantity, of the goods.”).
- 130 See *id.* at arts. 5, 6 quinquies(B)(iii). See also Bodenhausen, *supra* note 126, at 70, 116 (indicating that “[an appropriate condition for issuing a compulsory license] may be the case when patents concern vital interests of the country in the fields of military security or public health,” and also indicating that “[t]he purpose of this addition [to Article 6quinquies(B)(iii)] was to enable member States to refuse or invalidate trademarks containing suggestions that the goods concerned possessed non-existing qualities.”).
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- 144 Rachel Brewster, [The Surprising Benefits to Developing Countries of Linking International Trade and Intellectual Property](#), 12 CHI. J. INT'L L. 1, 6 (2011).
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- 146 TRIPS, *supra* note 10, art. 1(1).
- 147 See *id.* art. 3(1) (providing the caveat that this provision is subject to any Paris Convention exceptions).
- 148 *Id.* art. 42.
- 149 See Patricia L. Judd, [Towards a TRIPS Truce](#), 32 MICH. J. INT'L L. 613, 622 (2011).
- 150 TRIPS, *supra* note 10, arts. 44-45, 57.
- 151 *Id.* art. 31(i). See also *id.* arts. 44-45 (explaining injunctive relief and damages); *id.* art. 41(4) (“Parties to a proceeding shall have an opportunity for review by a judicial authority of final administrative decisions and, subject to jurisdictional provisions in a Member's law concerning the importance of a case, of at least the legal aspects of initial judicial decisions on the merits of a case.”).
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- 157 Reichman, *supra* note 8, at 385.

- 158 Brewster, *supra* note 143, at 6, 34 (“[T]he civil system might, in practice, be far more important than the administrative or criminal system if foreign rights-holders are willing to bear the costs of detecting and prosecuting intellectual property infringements.... In areas such as pharmaceuticals, private suits are cost-effective because the capacity to reverse engineer and reproduce pharmaceuticals is not as widespread. There may be only a few firms in the country.”).
- 159 See Antonia Eliason, [Science Versus Law in WTO Jurisprudence: The \(Mis\)Interpretation of the Scientific Process and the \(In\)Sufficiency of Scientific Evidence in EC-Biotech](#), 41 N.Y.U. J. INT'L L. & POL. 341, 361 (2009).
- 160 Lee, *supra* note 20, at 595. See also Patrick Zylberman, *Making Food Safety an Issue: Internationalized Food Politics and French Public Health from the 1870s to the Present*, 48 MED. HIST. 1, 25 (2004) (“The SPS Agreement ... intended that science should play the key role so that food safety could be separated from high foreign policy. Detached from culture, the issue of food protection would thus depend on a single regulator--science, the criterion for evaluating all other standards. This was, of course, either arrant naivety or cynicism.”).
- 161 Lee, *supra* note 20, at 576 (citing EUR. COMM'N, 15H ANNUAL REPORT ON UNITED STATES BARRIERS TO TRADE AND INVESTMENT 23 (1999) (The report states that U.S. nutrition labeling requirements differ from international labeling standards set by the Codex Alimentarius Commission and present “serious negative consequences on EU-U.S. trade in foodstuffs.”). See Obijiofor Aginam, [Food Safety, South-North Asymmetries, and the Clash of Regulatory Regimes](#), 40 VAND. J. TRANSNAT'L L. 1099, 1100-03 (2007) (discussing the issues of food safety within the context of economic globalization and the regulatory regime of WTO SPS). For a discussion of the interaction between WTO trade rules (GATT XX(d) health exemptions and a review of the SPS process) with other GATT rules and domestic health regulatory regimes, see CATHERINE BUTTON, *THE POWER TO PROTECT: TRADE, HEALTH AND UNCERTAINTY IN THE WTO* (2004).
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- 164 Peter K. Yu, [Six Secret \(and Now Open\) Fears of ACTA](#), 64 SMU L. REV. 975, 977-78, 980-81 (2011) (“Originated more than five years ago, ACTA built on pre-existing anti-piracy and anti-counterfeiting efforts, such as the Global Congress on Combating Counterfeiting and Piracy (Global Congress), Japan's proposal for an anti-counterfeiting treaty, the United States' STOP! (Strategy Targeting Organized Piracy) Initiative, and the European Commission's Strategy for the Enforcement of Intellectual Property Rights in Third Countries (E.U. IPR Enforcement Strategy).... In November 2005, Japan officially presented the proposal for an anti-counterfeiting treaty in the Second Global Congress in Lyon, France, an event jointly organized by the International Criminal Police Organization (Interpol), the World Customs Organization (WCO), and the World Intellectual Property Organization (WIPO) in partnership with the International Chamber of Commerce and its new Business Action to Stop Counterfeiting and Piracy (BASCAP) initiative, the International Trademark Association (INTA), and the International Security Management Association.”).
- 165 Press Release, Office of the U.S. Trade Representative, *Ambassador Schwab Announces U.S. Will Seek New Trade Agreement to Fight Fakes* (Oct. 23, 2007), available at <http://www.ustr.gov/ambassador-schwab-announces-us-will-seek-new-trade-agreement-fight-fakes>.
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- 168 *Id.* §§ 2-3.
- 169 Margot Kaminski, [The Origins and Potential Impact of the Anti-Counterfeiting Trade Agreement \(ACTA\)](#), 34 YALE J. INT'L L. 247, 250 (2009).
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- 174 *Id.* art. 9, P 1 (noting that parties must provide “judicial authorities ... the authority to order the infringer ... to compensate for the injury the [IPR] holder has suffered as a result of the infringement”).
- 175 *Id.* art. 10, PP 1-2 (explaining that counterfeit goods, and all materials used in the production of such goods, can be destroyed at the IPR holder's request, and that ACTA authorizes relevant parties to carry out the disposal/destruction of the goods at the infringer's expense).
- 176 *Id.* art. 11 (indicating that parties can seek to compel the release of information pertaining to infringement situations).
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- 241 See 1988 Swiss-Uruguayan BIT, *supra* note 186, arts. 1, 5.
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had resulted in Brazil having less than a 1 percent share in global trade, despite its population representing almost 3 percent of the world's population in 1990. The accumulation of problems from high levels of debt and inefficient state-owned industries induced Brazil to rethink its strategy to a more market-driven and trade oriented approach.”).

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