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Evolving Norms at the Intersection of Health and Trade

Jeffrey Drope, Ph.D.

American Cancer Society jeffrey.drope@cancer.org

Raphael Lencucha, Ph.D.

McGill University raphlencucha@yahoo.ca

Abstract

There has been growing tension at the intersection of health and economic policymaking as global governance has increased across sectors. This tension has been particularly evident between tobacco control and trade policy, as the international norms that frame them – particularly the Framework Convention on Tobacco Control and the World Trade Organization (WTO) – have continued to institutionalize. Using five case studies of major tobacco-related trade disputes from the principal multilateral system of trade governance – the WTO/General Agreement on Tariffs and Trade – we trace the evolution of these interacting norms over nearly 25 years. Our analytic framework particularly focuses on the actors that advance, defend and challenge these norms. We find that an increasingly broad network, which includes governments, intergovernmental organizations, non-governmental organizations and members of the epistemic community, is playing a more active role in seeking to resolve these tensions. Moreover, key economic actors are beginning to incorporate health more actively in their messaging and activities. We also demonstrate that the most recent resonant messages reflect a more nuanced integration of the two norms. The tobacco control example has direct relevance to related policy areas, including environment, safety, access to medicines, diet, and alcohol.

Addressing the enormous implications of tobacco remains one of the world's most pressing public health challenges. Tobacco-related disease kills nearly six million people each year, with low- and middle-income countries increasingly shouldering the enormous health and related economic burdens (Mathers and Loncar 2006). Projections suggest that these tobacco-based health challenges will only continue to grow rapidly as tobacco firms push particularly aggressively into developing countries with young populations, limited overall awareness of the dangers of tobacco use, growing incomes and often delicate political systems.

As one significant part of efforts to address tobacco and other major health challenges, the global public health community has pursued new governance opportunities. In particular, the World Health Organization (WHO) has begun to utilize its constitutional ability to facilitate the development of international health law. For example, under the WHO's auspices, a wide-ranging collection of tobacco control proponents brought to fruition the first – and presently, only – global public health treaty, the Framework Convention on Tobacco Control (FCTC). In the eight years after coming into force in early 2005, it has attracted 176 parties.

The treaty compels parties through both binding commitments and voluntary guidelines to implement and enforce a set of evidence-based tobacco control policies and practices, including: tax increases on tobacco products; smoke-free policies in public places and work environments; bans on tobacco advertising, promotion and sponsorship; large and graphic warning labels on tobacco packaging; and mitigating tobacco industry interference in health policy making. Compliance with FCTC commitments, while improving in many countries, continues to vary widely across parties (WHO 2011a). This variance in FCTC implementation is not surprising given the differing resource capacity, government will and international engagement (among other variables) across countries.

While the FCTC in some ways has been a watershed moment for the global health and tobacco control communities, it is crucial to note that it shares broader international governance space with many other types of international agreements, including trade, investment, human rights, customs and environmental, all of which seek or at least purport to protect and promote adequate standards of living for individuals. As wider formal cooperation among countries evolves, so do the inherent variation and complexities that characterize these accords. The development of these governance spheres almost inevitably generates tensions between international standards of policy behavior, or what are commonly termed, norms.

In recent years, important norms regarding countries' trade and public health policies have been struggling to co-exist. In the late 2000s, serious tensions re-surfaced between the emerging international norm of tobacco control and the well established norm of open trade, which seeks to reduce barriers to trade for the ultimate goal of promoting economic growth. Many members of the public health community have characterized the struggle as one wherein economic goals have typically dominated health issues (e.g. Callard et al 2001; Mamudu et al 2011; Shaffer and Brenner 2004; Shaffer et al 2005). Tobacco control proponents continue to express concern over the vast resources of highly-organized multinational tobacco firms as they seek to use international economic commitments to pursue their well-defined financial interests, often at the expense of or in direct conflict with efforts to regulate health-related issues and products. In contrast, observers suggest that the more disparate health community has been pushed to play a more defensive role as it attempts to compete for governance space and rally its varied interests and more limited resources to protect health. These tensions between trade and health protection exist in other areas including intellectual property protections for vital medicines and has become a crucial area of interest for policymakers dealing with health-related product regulation and human resources for health.

But the relationship between the two norms is much more complex than most observers acknowledge and recent actions at their intersection indicate a noticeable and traceable evolution of both the policy discourse and the behavior of key actors. Specifically, even in the face of an aggressive tobacco industry and its allies, public health norms, in the form of tobacco control measures, appear to be gaining some traction, notably among high-level economic policy decision makers. There is remarkably little discussion of this important evolution and understanding and explaining it would engender much more sophisticated discussion about the challenges, opportunities and next steps for the international public

health community in this highly contentious and consequential area. What is also noteworthy is that the trade sphere is being challenged to harmonize and explicate the meaning of health exceptions embedded in its rules, particularly in World Trade Organization (WTO) law. This meaning-making is occurring in the context of upholding the foundational norms of non-discrimination in trade practices and the necessity of domestic regulatory practices in light of the norm of open trade.

While the broader trade-public health discussion has largely focused on the negative effects of trade on public health and has frequently offered a simple solution of excluding tobacco from trade and other international economic agreements, it has not yet focused on states' broader conceptualizations of how to integrate different policy-specific international obligations that run into tension. We argue that work in this area has largely neglected both the recent changes in discourse at the intersection of tobacco control and trade policy, and the evolving nature of relevant policy initiatives and the reactions to them. The discussion has also missed a closer examination of the conditions that are contributing to these changes. While it is clear that the norm of open trade helps to shape most governments' economic policymaking, much of the existing literature on the trade-tobacco control nexus suggests that health norms have remained weak in the face of these open trade norms, including negotiators' initial inability to incorporate trade into the FCTC in a concrete and meaningful manner (Mamudu et al. 2011). Few scholars, however, have discussed the nuanced tensions between public health and trade policies specific to the concept of international norms and how and why policymakers are beginning to integrate these two broader policy objectives more successfully.

This research examines the norms-related tensions between tobacco control and open trade and presents a two-fold focus on the evolving nature of both the norms message and the messengers. In terms of evolving messages, we focus on three key strategies that many tobacco control proponents are increasingly and effectively utilizing: 1) couching arguments more consciously in language familiar to trade policy practitioners that also overtly seeks to integrate the two policies rather than categorically reject the principles of open trade; 2) more confidently and cogently invoking parties' international legal commitments to health agreements, including the FCTC; and 3) continuing to promote the vigorous use of scientific evidence to support norms integration (i.e. evidence of the legitimacy and necessity of health measures).

Second, the pool of messengers that form a broad network to support the proactive integration of health and trade is growing in size and changing in composition. While some of the early messengers – including tobacco control activists, scholars, and intergovernmental organizations (IGOs) – continue their efforts, there is a new set of messengers that actively link public health and trade. For example, we will demonstrate how trade representatives from a growing number of influential countries have been endorsing policies that affect trade and openly support public health goals. Similarly, trade organizations including the WTO have been using public health explicitly and purposefully in their decision-making. Although the health norm is embedded in WTO law, such as Article XX(b) of the General Agreement on Tariffs and Trade (GATT), which provides for a general exception in instances to protect health, health proponents have traditionally viewed

WTO law in conflict with health objectives. This view seems to reflect the idea that the trade norms remain dominant in the international context at the expense of other norms that inhabit the realm of “low politics” (Labonté and Gagnon 2010). Contrary to this view, the health norms appear to be gaining traction within the trade context, receiving considerable and often positive attention in the international community, including in international trade meetings and from the governments of major emerging economies. Recent evidence suggests that even many trade-focused actors are seeking to integrate the two broad norms more meaningfully. This research examines how the norms context (i.e. norms messages and messengers) has evolved from one of the first prominent tobacco-trade disputes in the principal pre-WTO trade forum – the original GATT agreement – in 1990 to four recent tobacco-related international trade disputes in its successor regime, the agreements (including the revised 1994 GATT) that comprise the WTO.

We begin by introducing a theoretical discussion that integrates a norms-focused approach drawn in large part from international relations with broader approaches from the rich public policy literature. This discussion includes a brief explanation of norms generally, but also specific to trade and tobacco control. Next, we introduce the 1990 GATT dispute about Thailand's ban on imported cigarettes as a baseline for comparison. This dispute between the United States and Thailand was the first major case within the GATT system related to tobacco. Following this dispute there was a period of almost two decades before the next tobacco-related challenge was brought forward at the WTO. Within this period, global tobacco control evolved, including the development and negotiation of the Framework Convention on Tobacco Control which came into force in 2005. We then examine developments in national-level tobacco control policies in Canada, the U.S. and Brazil involving tobacco flavoring and additive bans and packaging restrictions in Australia that opponents have questioned or formally challenged in the existing international trade regime. With each case, we begin by introducing the content of the disputes, in part to demonstrate that legal solutions are only one part of the complex intersection of health and trade spheres. Within each discussion, using our integrated theoretical framework, we focus on elucidating the nature of the discourse amongst the key actors including their messages and the nature and behavior of the messengers. We conclude by discussing the implications of the changes in discourse and behavior in health policymaking more generally as the themes examined here have implications beyond tobacco to other areas including alcohol, diet, medicines and the environment.

International Policy Norms – Tobacco Control and Free Trade

We utilize an integrated theoretical framework that incorporates analytic approaches to domestic public policymaking with international relations scholars' efforts to explain how domestic policies fit into broader commitments to formal international agreements. Many international relations scholars argue that “norms” (i.e. countries' standards of behavior) help to explain how ideas and policies move from the domestic to the international levels and vice versa. Among other attributes, the public policy literature offers utility in helping to explain both process and agency. Particularly relevant to the international economic policy-domestic health regulation dynamic that we examine here, the concepts of issue framing, issue networks and policy entrepreneurs help us to understand how ideas become policy or

standards of practice and diffuse within and across countries. The two broad approaches are complementary in this complex context of governance at the intersection of health and trade that has strongly interrelated domestic and international components. These approaches also contribute to the study of the intersectoral challenges of developing and implementing health policy by focusing on the ideas, interests, discourse and behavior of policy actors.

An international norm refers to a collective understanding of a standard of behavior or expectation of key international actors, which include but are not necessarily limited to states (Finnemore and Sikkink 1998). Norms are typically specific to an issue area such as the environment, human rights or economic activity. Many scholars implicitly adopt a norms perspective, for example, when they examine how standards of human rights influence or are influenced by political and social action at the international and domestic level (Hathaway 2002; Singh et al. 2007). The norms framework is useful to explicate the different intersecting, complementary and oppositional understandings of what “is” happening and “ought” to happen in global policymaking. For example, the strong oppositional response by the tobacco control community to trade disputes that challenge tobacco control measures reflects the position that health norms should take precedence over economic interests (e.g. Callard et al. 2001; Shaffer and Brenner 2004). Scholars argue that states exist within an international system that is largely framed by broad and deep networks of social relationships that affect how states perceive the world and the roles that they choose to or are expected to play in it (e.g. Keck and Sikkink 1998; Sunstein 1997). Many norms socialize state actors into seeking specific types of policies that are acceptable – even encouraged – by important members of the international community, which includes other states, IGOs and civil society organizations, among other entities. The power of norms is reflected in part by the compliance of state actors to voluntary international agreements that are largely difficult to enforce through traditional mechanisms of coercion (Koh 1997). Finnemore and Sikkink (1998: 892) note that we are able to recognize the breaking of norms because “it generates disapproval or stigma and norm conforming behavior either because it produces praise ... or because it is so taken for granted that it provokes no reaction whatsoever.”

Often, after widespread acceptance by important international actors, norms begin to develop deeper institutional characteristics. In particular, actors seek codification of the standard, perhaps in the form of an international agreement or treaty that is in many cases legally binding. Proponents of certain norms may seek still greater levels of institutionalization, frequently in the form of a more tangible institution – i.e. more than a written agreement – that demonstrates stronger capability to monitor and enforce compliance (Simmons and Martin 2002). One highly pertinent example described below of the norm of open trade institutionalizing over time is the development of the first General Agreement on Tariffs and Trade (GATT) into the WTO. Only recently, with the establishment of the FCTC, are we seeing more concrete international institutionalization of health norms related to tobacco control. For example, with the establishment of the FCTC was the creation of a Convention Secretariat that serves to facilitate the implementation of the agreement's provisions and to coordinate these activities with other United Nations agencies. The establishment of a Secretariat is one example of the institutionalization of mechanisms to support norms proliferation and diffusion from the international to domestic

level (Bauer 2006). The propagation of norms can become systematized through this development of legal instruments and the establishment of institutional arrangements specific to the norms that undergird them.

The public policy literature can contribute meaningfully to a conceptual framework within which we can situate an explanation of how norms develop within countries and across them, including focusing particular attention upon who is involved and how these actors present and promote (or oppose) the norms. To begin, problem identification plays a key role in precipitating changes in norms. In this case, the context is more complex because we are seeking to understand and explain the dynamic that develops when two major policy norms come into tension. Some stakeholders perceive unresolved tension between norms as a problem. The uncertainty of how to reconcile these tensions creates a situation wherein key actors are challenged to make effective policy. In this research, many in the public health community argue that the tension between international economic and domestic-level health policy commitments is an obstacle to progress toward healthier societies. As Walker (1981) notes, actors often first identify a problem when there is a gap in performance. The gap in this broad trade-health scenario became particularly evident in the late 1980s when the U.S. challenged Thailand's import ban on cigarettes, and then re-surfaced in the late 2000s when the tobacco industry and its allies (including the governments of some countries) began to argue that some countries' health-based policies came into direct tension with trade commitments. When it appeared that governments might be privileging trade and investment issues in the face of such tensions, many in the public health sphere began to conceptualize international economic commitments as a genuine barrier to making effective domestic health policies. We suggest that the evidence from the five disputes discussed below demonstrates that how the problem was framed at the outset was an important factor in how the solutions were constructed by the various actors.

Once actors have identified a problem, the next logical step is to formulate and promote solutions. To achieve these goals, developing an effective message is crucial, but this process can take time. In this sense our theoretical approach involves an evolutionary perspective that sees the message (i.e. problem and solution) change over time, but that this change is not neutral but rather becomes refined and better suited to solving the policy problem. Sometimes, to be more effective, the message must take a new form and proponents might even need to construct new knowledge (Brandt 2007). Nathanson (1999) articulates how the gun control debate in the U.S. changed when it was re-framed as a medical issue and began to demonstrate credible risk. Similarly, Brandt (2007) argues that the smoking debate in the U.S. changed markedly in favor of public health when the U.S. Surgeon General cast the issue in epidemiological terms – e.g. the numbers of premature deaths or avoidable sicknesses, etc. In the case of integrating public health and economic policies, the task requires substantial input from the legal, economic and health communities. The health sector's early struggles are likely, at least in part, the result of not engaging the existing economic and legal frameworks and actors sufficiently. The complexity of the issues – and particularly the fact that the different sectors often lack meaningful understanding of the others – suggests that resolving these policy challenges is very difficult.

A major strand of the public policy literature places considerable theoretical emphasis on “who” is identifying problems and promoting (or opposing) solutions – or what many IR scholars might characterize as the actors supporting/opposing an existing norm or perhaps promoting a new one. Many scholars pay particular attention to private (i.e. non-governmental) interests. In particular, research focuses in considerable part on the characteristics of the interests (e.g. structure, resources, expertise, etc.), the incentives and constraints they encounter, and the combination of the two. In theoretical terms, an interest-driven argument is undoubtedly helpful for explaining the role of one of the key actors, the tobacco industry, that drives policies privileging economic outcomes over health. The industry clearly has a set of characteristics that suggest a superior capacity to affect the policy process: it is surely one of the best organized, well-resourced and singular-minded (i.e. profit) business interests in the world. What is particularly salient for this research is the question of who is saying what in the context of tobacco-related trade challenges. This analytic frame does not assume that interests or preferences can be reduced to actors. In other words, we suggest that it is vitally important to examine what policy actors are saying about an issue, as for example, trade representatives may express markedly different positions on the trade-tobacco control issue. Although this analytic lens may seem redundant because of its simplicity, it is sometimes neglected in the health policy literature.

To help explain why health appears to be gaining ground, we utilize Heclo's concept of an issue network (Heclo 1978). Heclo argues that issue networks can be loose and varied coalitions of actors – which can include traditional interest groups, members of epistemic communities, foundations, international organizations and economic actors, among any number of others – who organize to influence a specific issue. This conceptualization of issues and networks is consistent with “transnational advocacy networks” from the international relations norms literature (e.g. Keck and Sikkink 1998). The case studies below demonstrate that quite varied groups of actors have come together to defend the health objectives of tobacco control measures in these significant trade policy-based challenges. We observe the broad and heterogeneous public health community come together during this time period in new ways. For example, a prominent coalition of health-based, non-governmental organizations (NGOs), the Framework Convention Alliance, was consolidated through the process of FCTC negotiations and is now an incorporated entity and is seen by states as a credible voice in global tobacco control (Lencucha et al. 2011, 2012; Mamadu and Glantz 2009). Additionally, a number of large NGOs with global reach have mobilized funds to work on the issue of trade and tobacco control, including the International Union Against Tuberculosis and Lung Disease, the Campaign for Tobacco Free Kids and the American Cancer Society. There has also been a notable increase in the number of trade lawyers consulting within the health network. We argue that over time, through these types of actors and/or with their assistance, the opportunities to organize disparate actors around the trade-tobacco control nexus have grown.

Issue network frameworks do not typically emphasize highly specific agents and the narratives in this research suggest that persuasive – and sometimes powerful – individuals sometimes have marked effects on policy discourse and formation, and the promotion of new norms, or at least the re-consideration of established ones. Oliver (1991) calls them “policy entrepreneurs” and there have been many in global public health generally and

tobacco control specifically. In later work, Oliver (2006) sums up their role: “In addition to developing and promoting their policy products, policy entrepreneurs attempt to manipulate the dimensions of a policy debate, reshaping their ideas to fit the political and economic constraints of the moment and to gain access to policymaking venues” (218). As we observe even in the early case involving Thailand, individuals as much as formal institutions actively sought to influence the process particularly by playing such a large role in developing a new discourse that was compelling to a wider range of actors (Frankel 1996).

Trade and tobacco control norms

Though the idea of open trade – the exchange of goods and/or services with few or no barriers – has existed for centuries, the norm of free trade re-emerged more systemically and almost globally after World War II. Initially, the GATT primarily sought to liberalize trade in goods (i.e. reduction of tariffs, elimination of quantitative restrictions and the principle of non-discrimination). To further trade openness, the GATT members added layers of liberalization in subsequent rounds of negotiations. In 1994, with the conclusion of the Uruguay Round, members reached a new level of institutionalization when the WTO subsumed the GATT. Under the WTO umbrella, agreements address major aspects of the international trading system, many of which are relevant to tobacco control. In addition to a revised version of the GATT, agreements cover trade in services (the General Agreement on Trade in Services), intellectual property (Agreement on Trade-Related Aspects of Intellectual Property Rights or TRIPS), and Technical Barriers to Trade (the TBT agreement), among others. The WTO agreement also introduced a new dispute settlement system that is less ad hoc than the GATT's, is required to move more quickly, is more binding and can officially sanction and define the parameters of formal retaliation. Not only have many countries become members to agreements facilitating open trade – the WTO now has 157 member countries – but trade flows reached unprecedented volumes in 2012 (CBP 2012) and tariff rates in many countries are at or near historical lows.

Importantly, however, it has not been a linear march toward economic liberalization: in recent decades, there has been substantive and successful contestation of the open trade norm. Broadly speaking, during the ongoing but largely stalled Doha Round of WTO negotiations, a coalition of developing countries and international advocacy organizations has successfully held firm against strong pressures from many of the wealthiest countries to liberalize in areas in which these actors have serious concerns. Moreover, proponents of governments' regulatory autonomy have succeeded in preserving countries' rights to protect policies in areas such as access to medicines, the environment and safety, among others. For example, following immense pressure from civil society organizations and some developing countries, a WTO ministerial declaration in 2001 on the TRIPS Agreement and public health helped to enhance access to medications in resource-challenged countries (Dutfield 2008). Similarly, the Punta del Este declaration from the 2010 fourth Conference of Parties of the FCTC actively asserted countries' obligation to “give priority to their right to protect health” (WHO 2010: 2). The declaration goes further to reference the health protections embedded in both the TBT and TRIPS agreements.

Though the concept of tobacco control has been around in various forms since researchers established scientifically that tobacco use was harmful to human health in the 1950s, it is relatively new as a widely accepted international norm. Since the 1960s, a number of official health-related agencies from several developed countries (e.g. Horn 1962; U.S. Surgeon General 1964) and major international organizations such as the World Health Organization (WHO) and the International Union Against Cancer (UICC) (e.g. Gray 1977; WHO 1975) have championed the cause, but a widespread, deep and coordinated international embrace – i.e. standardized policies across many countries – of tobacco control as a norm has been slow to emerge. The reasons for this lag are many, including two decades of attention to infectious disease control in many low-income countries, the only relatively recent surge in tobacco consumption in these countries and systematic efforts by the tobacco industry to hinder the legislative process to control tobacco. In terms of both wider and deeper international institutionalization, one of the movement's landmark events occurred in 2005 when the FCTC, under the auspices of the WHO, came into force. The agreement rapidly attracted signatories: 176 Parties in less than eight years.

It is reasonable to argue that open trade has institutionalized more deeply than tobacco control when comparing the two norms. Though the FCTC does have a Secretariat within the WHO, it has limited resources available to it and its legal ability to compel members is considerably less compared to the WTO (or even the earlier GATT). For example, neither retaliation nor reciprocity is formally structured into the FCTC like it is in the WTO with its dispute settlement system. But the differences between the two agreements are much more nuanced. For example, despite less institutionalization, the many new tobacco control policies across the globe indicate its significant growth as a norm (WHO 2011a). More specifically, as discussed in detail below, when confronted with tensions concerning trade policy norms, recent outcomes have shown some compelling evidence that public health norms are gaining acceptance even in the face of more established economic norms.

Since both norms of trade liberalization and tobacco control are enshrined in formal international agreements, it might be reasonable to expect that tensions between them can be resolved legally. Certainly some legal solutions do exist, but the process of how to interpret possible conflicts and/or tensions between agreements judicially – often termed “normative integration” – is evolving and unlikely to provide easy resolutions in many cases (see McGrady 2011b). Indeed, the majority of legal disputes pertaining to global tobacco control and trade have emerged within the past five years. While overarching agreements intended for the purposes of integration, including the Vienna Convention on the Law of Treaties, help to resolve some issues, it is clear that many agreements generate conflicting interpretations and that while there are more definitive legal solutions to specific issues – e.g. formal dispute resolution – there are frequently no obvious overarching solutions to some broader legal questions (e.g. how to determine precisely when measures are “too” trade restrictive in the context of protecting health). Instead of utilizing legal means alone, states must seek resolutions in other manners, most notably politically. The heretofore mostly unexplored political dimensions of these resolutions suggest that we need to examine and then explain better how countries, as members of an international community, organize transnational affairs where economic and public health policies intersect.

In this research, we analyze the evolving discourse and norms-relevant behavior at the increasingly active intersection of tobacco control and trade policies. The cases are actual international economic disputes that serve to illustrate the challenges and opportunities that trade regulations pose for countries seeking to enhance their domestic public health legislation.

Methods: Content Analysis of Key Trade Disputes

In large part, we utilize analyses of the content of five international trade disputes related to tobacco control policy, in addition to the surrounding position statements and behaviors of relevant actors, to assess our arguments about the nature of changing norms. We selected the cases based on two major criteria. First, we chose cases that occurred within the same general context or mechanism – the GATT/WTO system – in order to control for confounding variables related to venue/forum, thereby generating a better comparison of how health norms (as enshrined in a formal international agreement) interact with trade norms. We selected the GATT/WTO system because it is the dominant international trade policy framework, and arguably the most important in terms of creating and/or perpetuating norms. Second, we specifically chose cases that involve challenges to national tobacco control legislation at the international level wherein many or most of the fundamental arguments focus on alleged violations of commitments to international economic agreements. For the purposes of generating a comprehensive discussion, we analyze all five GATT/WTO disputes that have developed at the tobacco control-trade intersection.¹ The U.S.-Thailand dispute in 1990 over Thailand's cigarette import ban represents the first significant public conflict over these norms. After a discussion of the discourse that ensued during a gap in formal disputes, we examine all four of the cases that have hotly re-ignited the debate about how countries might reconcile commitments to both trade and health. Thus, we are examining the universe of major disputes of this nature in this pivotal international forum.

We prominently utilize a review of the discourse surrounding each of the cases because there is compelling theoretical logic that discourse is an important precursor to actual norm and/or policy change. As Hajer (1993, 46) argues: “If a discourse is successful – that is to say, if many people use it to conceptualize the world – it will solidify into an institution, sometimes as organizational practices, sometimes as traditional ways of reasoning.” Thus, we seek to track these parallel and overlapping discourses in order to understand better how actual policy behavior may or may not be affected and/or changing. Naturally, beyond the examination of discourse, we also track changes in actual policy behavior. Although discourse can propel institutional development, the reverse is also true: institutional change can shape discourse. This is common when norms are instituted at the international level and then serve to shape domestic discourse. The initiatives undertaken by many of these governments and other entities suggest that some actors have moved well beyond discourse.

¹Three of the disputes became or have become formal panels that the GATT/WTO adjudicated or is adjudicating. The disputes involving Canada and Brazil represent sustained and vigorous formal discussion among a large group of members over several years and in many formal institutional contexts. There are no other substantive disagreements that represent this level of engagement.

This inquiry draws from two main sources of data. The first source is the public documents that were released throughout the five legal cases. These documents include GATT and WTO committee minutes, press releases, government ministry documents and dispute settlement documents (including panel reports). We compare the content of these official documents with a second large source of data that includes both legal commentaries and those presented by interested stakeholders, including IGOs, INGOs, the tobacco industry, civil society organizations (including think tanks) and academic practitioners. We searched the major legal databases (LexisNexis and Westlaw), the extensive databases of major IGOs (especially the WTO and WHO), and the standard academic databases. The documents were included for analysis based on whether they addressed directly or indirectly the five cases, or closely-related earlier cases (e.g. EC-Asbestos, EC-Biotech, etc.), and together provide a compendium of qualitative and quantitative data on which to base our analysis. Finally, we also utilized information from semi-structured interviews with four key informants who had involvement in these cases, and several less formal personal communications with key actors, particularly to clarify specific imprecisions in the evidence.

Our analysis involved a narrative review of the collected documents, which permits a certain level of flexibility and responsiveness to the content being analyzed (Cook et al. 1997). However, we conducted a rigorous analysis of the documents to evaluate our initial proposition that health norms are becoming more integrated into trade policy decision-making and that those actors who are bringing the “health message” into this arena are becoming more diverse. In particular, we carefully trace the process of the precise legal objections of the complainants, the arguments of the members seeking to defend their tobacco control regulatory decisions while attempting to remain consistent with their international commitments to open trade within the international trading regime (e.g. the WTO), and finally, subsequent reactions to these arguments. We also trace the rhetoric of extra-state actors including the WHO and the GATT/WTO itself as these entities seek to influence and/or react to these disputes. Last, the analysis involved a technical or clinical reading of the documents whereby we examined the precise legal components of the cases, particularly though not exclusively within the GATT/WTO system (Yin 1994). We work to provide a traceable description of the five cases by linking factual statements as well as interpretations to the documentary source. All of the analyzed documents are publicly available and those that we directly cite are provided in the reference list.

Thailand – Cigarettes

In the 1980s, the U.S.'s executive-level trade agency, the United States Trade Representative (USTR), through Section 301 of the 1974 Trade Act, aggressively sought to remove other countries' barriers to U.S. imports, including in some instances, tobacco products. While the USTR – with strong urging and support from the U.S tobacco industry – was successful in this goal in many countries, Thailand refused to remove its import ban on tobacco products, maintaining that the measure served health purposes. At the time, the Thailand Tobacco Monopoly (TTM) was the sole manufacturer and importer of tobacco in Thailand (Vateesatokit et al. 2000). The USTR not only dismissed the health argument, but insisted that it was a fundamental violation of particularly GATT Article XI, which prohibits quantitative restrictions on imports and exports. After failed bilateral negotiations to resolve

the issue (and a related tax issue), the U.S. government sought a formal panel in the GATT's dispute settlement system in October of 1989, which became the first high-profile international trade dispute involving tobacco products, Thailand – Restrictions on Importation of and Internal Taxes on Cigarettes (or, *Thailand – Cigarettes*).

As a landmark dispute at the intersection of trade and health, and specifically tobacco, it is important to consider the characteristics of the case, particularly in order to set a benchmark for the discussions of and behaviors around these issues in subsequent cases. From a broad perspective, in terms of the nature of both the tobacco control messages and the messengers, there was a very strong emphasis on health, though there were also preliminary signs of cooperation between some health and more economically-focused actors. To begin, Thailand framed its arguments in defense of its import ban principally around health. With this health focus in mind, Thailand also demanded that the panel consider the input of the World Health Organization (WHO), which became an important actor in the panel proceedings. The following excerpt was drawn from the final Report of the Panel in 1990:

Since the health consequences of the opening of cigarette markets constituted one of the major justifications for Thailand's cigarette import regime, Thailand deemed it necessary that the panel consult with experts from the World Health Organization (WHO) on recent experience in countries which had been made to open their markets for cigarettes. This showed that once a market was opened, the United States cigarette industry would exert great efforts to force governments to accept terms and conditions which undermined public health and governments were left with no effective tool to carry out public health policies (GATT 1990: para 27).

The WHO based much of its position in support of Thailand on health-specific scientific evidence. The WHO representative provided a detailed description of the harmful effects of tobacco use and the risks involved in opening the market to US tobacco companies, noting that “if the multinational tobacco companies entered the market, the poorly-financed public health programmes would be unable to compete with the marketing budgets of these companies, as had been the case in other Asian countries whose markets had been opened. As a result, cigarette consumption and, in turn, death and disease attributable to smoking would increase” (GATT 1990: 15). The WHO representative did not address the trade commitments being raised by the US delegation in this case and focused instead on the health consequences of open trade.

Second, Thailand did not seek, at least initially, to address if or how its import ban might integrate with central principles of the GATT system. For example, the Thai arguments did not make immediately clear how measures fit with the principle of non-discrimination. There was also an initial lack of conceptual clarity in terms of the issue of the necessity of the ban in light of understanding how alternative tobacco control measures might serve similar purposes, though as we will discuss below, necessity became the core of the panel's ruling. In some contrast, and perhaps a harbinger of future decisions, the panel also chose to comment explicitly on what types of public health strategies would be consistent with the rules-based international trading system.

Led by several influential individuals in the Thai health community, with help and guidance from colleagues from the international health community, Thailand framed its defense in large part around the preamble to the GATT. Specifically, Thailand argued that their import ban was consistent with the GATT's stated objective "to raise the standard of living, ensure full employment and a large and steadily growing volume of real income and effective demand..." (GATT 1990: para 21). Similarly, supporters of the ban cited GATT Article XX(b) arguing that the ban's objective was to reduce consumption of tobacco products and thus to protect health.

The relationship between health and commerce officials in Thailand began tenuously, though evidence from key actors involved in the process suggests that it evolved over time to become significantly more cooperative (Vateesatokit 2003). In the initial response to the threat of U.S. retaliation under Section 301, the Ministry of Commerce, along with Thai exporters, initially came out in strong support of lifting the ban. It was in considerable part through pressure from both the Thai and international health communities – with the support of the Thai Tobacco Monopoly – that the Thai government chose to defend the issue on health grounds, not because economic actors in the government considered it the preferable economic policy (Chantornvong and McCargo 2001). When health officials first joined the Thai trade delegation seeking to negotiate a solution with the USTR, there is little evidence to suggest that the economic and health authorities were working in concert on the negotiation. Economic authorities were concerned that health authorities would take strong positions that might undermine efforts to resolve other key trade issues. Reportedly, however, health officials helped to strategize successfully in the negotiations and won the trust of the trade officials so much so that the permanent secretary of the Ministry of Commerce publicly suggested that it was an opportune time to reorient Thailand's domestic health policy toward much stronger tobacco control (Vateesatokit 2003). In this way, a group of wide-ranging, though primarily health-focused actors – domestic health and commerce officials, the WHO and foreign health organizations – coalesced around the cause, developing into what many policy theorists would describe as an issue network, or at least the genuine beginning of one. Moreover, this movement was spearheaded by a small group of individuals, both within the Ministry of Health and representing a national tobacco control NGO, suggesting that policy entrepreneurs were catalytic in galvanizing the network.

At the request of Thailand, the WHO was a significant presence at the GATT panel proceedings, in which it gave substantial input, based principally on health-focused arguments and suitable strategies to protect citizens from the harms of tobacco use. According to a WHO representative present at the hearings, the WHO based their testimony in considerable part on a 1982 WHO report on standards in tobacco control in developing countries (personal communication, March 5, 2013). Scholars have noted the importance of the WHO's participation in this panel for the broader international governance framework because it was the first time that the WHO had some influence in a major non-health forum (e.g. Brandt 2007). In fact, multiple sections in the final GATT panel report are dedicated to the WHO's arguments, which include: evidence about mortality and morbidity stemming from tobacco use; how manufacturers use additives to make tobacco products more palatable; targeting of women as new tobacco consumers; the efficacy of tobacco

advertising bans; the effects of previous market liberalization on tobacco consumption; and the efficacy of raising prices to lower consumption (GATT 1990: paras 51–57). The WHO placed less emphasis on how it might be possible to integrate trade and health in a policy-coherent fashion.

Input from third-party governments – either in support of or opposition to particular positions – is noticeably absent from this case based on examination of the panel process and eventual decision. There is little evidence that other countries were particularly vocal during the dispute – at least in official, on-the-record settings – which is in marked contrast to the deep interest that both detractors and supporters have taken in later tobacco-related trade disputes.

In many ways, perhaps in part by design of the Thai delegation to the GATT proceedings, the interpretation of the health-trade nexus was left considerably to the GATT panel. Though the panel ruled fairly narrowly in its decision, there were consequential developments in the panel report in terms of clarifying how norms might be reconciled at the intersection of trade and health within the GATT. First, the panel focused considerably on the concept of necessity. In what has since been cited widely in subsequent GATT/WTO panel decisions, in interpreting necessity in GATT Article XX(b), the panel adopted a “least trade-inconsistent” test (see GATT, para 74). The panel suggested that the measures would only be necessary if Thailand had no other options to address the health issues with policies or other strategies more consistent with GATT (GATT 1990: para 75). Critics have countered that the panel did not consider the costs of alternative measures sufficiently (e.g. Mattoo and Mavroidis 1997; Park 2001).

Yet, in addition to accepting the evidence that smoking poses genuine risk to human health, the panel chose to take the interpretation of “necessity” a step further and spoke directly to the issue of the permissibility of non-discriminatory – i.e. GATT-consistent – measures that countries could use to address concerns about protecting health. For example, referencing the WHO's testimony on tobacco control strategies, the panel ruled that in a similar situation, non-discriminatory advertising restrictions would be considered both necessary and consistent with GATT rules (e.g. GATT 1990: paras 77–78). Perhaps more remarkably, the panel even commented on the acceptability of measures that limited supply of tobacco products as long as such provisions were non-discriminatory. Arguably, these more proactive parts of the decision foreshadow similar suggestions made more than twenty years later by its successor WTO dispute settlement body in the *U.S. – Clove Cigarettes* decision discussed below. Moreover, proponents of public health in subsequent cases have clearly taken cues from the 1990 GATT decision in order to shape strategies and arguments, including clearer incorporation of the concept of necessity in the arguments in favor of tobacco control measures.

In sum, the *Thailand – Cigarettes* dispute demonstrates that patient, persistent and effective health proponents can persuade and even work with domestic and international trade officials with strong evidence-based public health arguments that the trade-focused actors can reconcile with their own normative beliefs and trade objectives. Similarly, though the issue network was small compared to later cases, the dispute suggests that a coalition of

diverse and international actors that includes NGOs, IGOs and government officials can work together to make a convincing case. Importantly, there is limited integration of the norms in this case, and perhaps surprisingly to many in the health community, it was more the trade IGO that sought to find explicit ways to reconcile the health and economic goals.

Post-Thailand – Cigarettes

Though there was a lull in formal trade disputes focusing on tobacco-related health interventions after the *Thailand – Cigarettes* case, the broader discussion about how to address these types of trade-health tensions continued, particularly amongst academics and political and non-political health and trade policy practitioners. For example, even after considering the increased consumption after rapid trade liberalization in several tobacco markets, Chaloupka and Laixuthai (1996) argued that many tobacco control measures are typically consistent with trade agreements, and that trade-discriminatory health measures might invite serious threats to trade more generally. The World Bank's seminal *Curbing the Epidemic* (1999) monograph about the economics of tobacco control makes a similar set of arguments that fundamental tobacco control interventions do not inherently contravene international trade agreements and that governments can develop policies that are both effective for engendering public health and consistent with international economic agreements. In a lively published debate, a high-ranking WHO official and a former USTR ambassador repeated these arguments (Bettcher and Shapiro 2001) while some members of tobacco control civil society organizations remained skeptical about the compatibility of trade and health (Callard et al 2001).

After the FCTC first came into force in 2005, and before the spate of cases discussed below, the general discussion about potential tensions between trade and health continued (e.g. McGrady 2007), and scholars also began to consider emerging issues, including bans on internet sales. In the official discussion within the FCTC process, including the negotiation of the illicit trade protocol, many experts (e.g. FCTC 2009) argued that tobacco control interventions are consistent with the rules and guidelines of the international trading system.

The intellectual and pragmatic policy debates specific to plain packaging of tobacco products and trade have continued for more than 20 years. Civil society (Physicians for a Smoke-free Canada 2008) and scholars (Crosbie and Glantz 2012) have demonstrated that most legal experts continue to argue that if executed in a non-discriminatory manner, plain packaging is consistent with international trade law. Moreover, the tobacco industry's own advisors and the relevant international organizations from which they sought input, such as the World Intellectual Property Organization (e.g. Baeumer 1994), have consistently suggested that the provision does not violate trade agreements. What is remarkable, and has remained mostly unexplained, the industry has continued to pursue – largely successfully – a strategy that emphasizes the provision's incompatibility with international economic agreements. Canada even had a working proposal on plain packaging in the mid-1990s, but abandoned their efforts after strong lobbying from the industry. But as countries such as Australia began to consider plain packaging again after the FCTC came into force, a coalition of experts and proponents in civil society, the academy, and some governments – once again, a veritable transnational issue network – continued to build the fundamental

legal and moral cases for it (e.g. Australian Preventative Health Task Force 2008; LeGresley 2006; McGrady 2009). The tobacco firms, anticipating a renewed battle, continued to stake arguments around the idea that plain packaging violates trademark protections (Philip Morris 2009). They also continued to enlist support from major business organizations including, for example, the U.S. Chamber of Commerce (2008). Importantly, led by an international and organizationally diverse contingent of strong proponents, the network in support of health persevered and Australia followed through with the legislation discussed in greater detail below.

Canada's Bill C-32

A 2009 Canadian law, Bill C-32, to ban certain tobacco additives and flavorings in an effort to help mitigate youth smoking has generated considerable international debate, particularly in the WTO. In large part because of a perception that certain varieties of tobacco might face larger negative ramifications from the policy, some WTO members with the strong support of the tobacco industry have raised concerns. The Canadian law did not go to formal dispute settlement but was challenged in number of official committee meetings within the WTO. The Canadian representative to the WTO has reacted swiftly and forcefully with a finely-tuned message that a) actively couches the discussion more in trade language than in public health rhetoric, b) carefully marshals scientific evidence, and c) cites countries' international legal commitments to the FCTC. Additionally, many WTO members are beginning to frame their objections to the measure in terms that at least rhetorically support improved public health protection.

The legislation faced particular scrutiny in official meetings of the WTO's TBT committee (WTO-TBT 2009, 2010a, 2010b, 2010c, 2011a). The principal trade-related issues fall within the official TBT Agreement, including: whether the measure is too trade-restrictive (Art. 2.2); its basis on the products' design and descriptive characteristics rather than the end use (Art. 2.3); and Canada's obligation to notify members to the TBT as to changes in law (Art. 2.9). Additionally, a handful of members have expressed concerns about how the law might affect developing country members to the agreement (Art. 12.3).

The Canadian government's representative to the WTO has articulated reasoned legal responses to each major objection, responding firmly and consistently both in TBT meetings and reportedly with certain members bilaterally (WTO-TBT 2010a: para 191). Most notably, these responses have been thoroughly framed utilizing a set of arguments that is both consistent with the broad principles of open trade, but also clearly and explicitly preserves countries' right to use domestic regulation to protect health. In the November 2009 official meeting of the TBT committee, the Canadian representative to the WTO reiterated that in pursuit of this regulatory measure, "Canada was committed to respecting its international trade obligations while meeting its legitimate public policy objectives" (WTO-TBT 2009: para 16). Concerning the issue of whether the measure is too trade restrictive, the Canadians reject some members' suggestion to ban only noticeable flavorings because it does not help to reach the policy's goal of banning additives that make smoking more attractive to young smokers, because non-flavored additives can also make smoking more palatable. This argument is particularly salient as the tobacco industry continues to draw in the youth

market on a global scale (Sebrie and Glantz 2007). Notably, and perhaps not surprisingly, the major transnational tobacco firms have denied that additives enhance the flavor of cigarettes, noting that “cigarettes taste like cigarettes and not like sweets or candy” (BAT 2007). In regard to design or characteristics versus use, the Canadians maintain that both documents from the tobacco industry and scientific evidence indicate that a variety of additives increase the attractiveness of tobacco products to youth. They also reject the argument that the measure is effectively a ban on cigarettes manufactured from blends of tobacco that typically use such additives – which are actually extremely uncommon in Canada – because the legislation bans no types of tobacco leaf nor any type of product. They also reject the concern under Article 2.9 of the TBT because notification is only required when a measure will generate major trade ramifications. Since the measure will affect less than 1% of imported tobacco products, the government deemed it not significant (WTO-TBT 2010c: paragraph 222). The Canadians employ similar logic to dismiss Article 12.3 concerns. One Canadian health official speculated that objections from WTO members with little or no trade with Canada were likely rooted deeply in members' connections to the tobacco industry (personal communication, November 14, 2012).

The Canadians have also addressed the complexities of “trade restrictiveness” by moving beyond the over-simplified interpretation that countries should choose regulations that least interfere with trade by also considering the financial and health costs of not implementing appropriate regulations. In a recent TBT committee meeting, the Canadian WTO representative “recalled that tobacco use was a contributing factor to serious chronic diseases such as cancer, respiratory ailments and heart disease that accounted for approximately CAD4.4 billion in direct health care costs each year in Canada” (WTO-TBT 2010a: paragraph 203). This approach adds a more nuanced perspective to the issue of necessity, and by employing health- and finance-based evidence, there is an important confluence of trade policy interpretation and evidence-based demonstration of harm, particularly considering the nature of the TBT agreement, which does not include a formal public health exception.

Moreover, for the first time in an official WTO committee meeting, Canada's WTO representative strongly defers the issue to its – and most WTO members' – international treaty commitments to the FCTC. It cites the FCTC's use of international best practices and the scientific literature. In the case of additives specifically, it has invoked its participation in the Article 9 and 10 process:

...these issues were better addressed within the FCTC Conference of the Parties. Canada was one of a number of countries involved in working groups to develop guidelines for the implementation of the FCTC. Activities to further the implementation of the FCTC took into account best practices and scientific and medical literature from around the world. (WTO-TBT 2010a: paragraph 210)

It is not just Canada's remarks in which we observe changes in the norms-related rhetoric. In spite of members' explicit concerns about the measure's consistency with WTO commitments, the preponderance of objecting countries consistently preface their official remarks in the TBT committee meetings with expressed support for the Canadian law's goal of preventing youth smoking.² Though not binding in any way, this rhetoric at least

demonstrates emerging overt support for public health from trade officials. For example, in the November 2009 TBT committee meeting, the minutes record the Argentine representative, among many others, stressing “that his delegation supported Canada's objective to prohibit the production and marketing of tobacco products which could attract youth” (WTO-TBT 2009: para 8). Notably, there is little evidence of similar widespread rhetoric acknowledging the legitimacy of the specific regulatory issue when we review WTO committee minutes about related environment, health and food safety disagreements (e.g. asbestos, biotech products, etc.).

Moreover, also for the first time in official WTO meetings, consistent with the Canadians' invocation of its FCTC commitments, other members, including the EU, also explicitly cite the binding and non-binding provisions of the FCTC. The official minutes of the March 2010 TBT meeting note: “The representative of the European Union strongly supported Canada's objective of protecting human health and, in particular, deterring youngsters from smoking, which was in line with the WHO Framework Convention on Tobacco Control” (WTO-TBT 2010a: paragraph 198). Similarly, at the same meeting, the Former Yugoslav Republic of Macedonia tacitly acknowledged the binding nature of the FCTC asking whether there were other measures that Canada could implement to “find a better balance between the obligations which arose from the Framework Convention on Tobacco Control (FCTC) and economical aspects of the tobacco producers which had great social and economic impacts in developing country ...” (paragraph 203). The representative's use of the word “obligations” is a particularly telling normative consideration of these commitments.

According to a lawyer who has worked closely with the Canadian government on related health issues, the Canadian ban was spearheaded mainly by a small group of officials in the federal health ministry, Health Canada, who believed strongly that additives and flavorings present a genuine threat to the health of the country's citizens (personal communication, February 21, 2013). These policy entrepreneurs not only conceived of the ban, but anticipated the kind of opposition using economic arguments that it was likely to face, particularly from the industry and its allies. Accordingly, the officials consulted considerably with actors in other key ministries, including the Department of Foreign Affairs and International Trade (Choinière 2010). As a result of this coordination, the Canadian WTO delegation was well prepared with its arguments to justify the health measure's consistency with international trade rules. The ban has also been strongly and vocally supported by the domestic tobacco control and public health NGO community. The issue network has demonstrated sufficient breadth across sectors to withstand a wide range of arguments, including economic ones, from opponents.

The Canadian C-32 case suggests that well-informed domestic health officials can work closely and effectively with their trade counterparts to defend public health regulations

²The following 18 WTO members expressed concern or raised general questions about the legislation but explicitly supported its public health goal in a TBT committee meeting: Argentina, Brazil, Chile, Croatia, Cuba, Dominican Republic, Guatemala, Honduras, Jordan, Macedonia, Mexico, Mozambique, Philippines, Switzerland, Tanzania, Turkey, Uganda, and the U.S. The following nine objecting or concerned members did not voice support for the measure's overall public health goals: Burundi, Colombia, Ecuador, Egypt, Indonesia, Kenya, Malawi, Zambia and Zimbabwe.

successfully in the face of major challenges using alleged commitments to international economic agreements. This cooperation represents a notable shift in the policy-related behavior of these trade officials. In a related development, we also observe that other countries' trade delegations are at least careful to preface their objections by paying explicit respect to the health goals and in some cases even to the primacy of the FCTC. Perhaps this is more a shift in discourse than actual policy behavior, but it has been a notable development nonetheless at the trade-health intersection.

Australia's plain packaging initiative

In the lively debate about Australia's legislation for plain packaging of tobacco products,³ the nature of the message and the messengers has evolved from the 1990 Thai case. First, within the discussions in major WTO discussion forums (e.g. WTO-TBT 2011b, 2011c; WTO-TRIPS 2011a, 2011b) and other venues, Australia – from both the health (Lateline 2011) and trade (ICTSD 2011) ministries – is firmly invoking its inherent right within the parameters of international economic agreements to protect the public health of its citizens. Second, there is evidence of an increasing number of countries' trade representatives continuing the trend of the general support for tobacco control in meetings about international trade policy (which began with the case concerning Canada above), by using the language of trade policy, citing the FCTC and strategically employing scientific evidence. Finally, a domestic and international issue network has coalesced tightly around the initiative, including vocal and official support from IGOs. Internationally, the WHO has been more assertive in actively seeking to influence the WTO process, particularly by invoking confidently the legally-binding nature of parties' commitments to the FCTC. Clearly, this strategy was not an option open to the WHO in 1990, but it is clear that the WHO is starting to affirm its own legal authority more forcefully.

Among a number of issues at the WTO, the main concerns have included whether the measure is too trade restrictive and if there is sufficient scientific evidence to support plain packaging. In the TRIPS Council meetings, discussion centered mainly on various aspects of trademarks under the TRIPS Agreement, including both the protection of other members' trademarks (Articles 15 and 17) and unjustified barriers to them (Article 20).⁴ The Australian WTO representative's firm response to these concerns has been based on public health, and in particular that, even as a global leader in tobacco control policy, the government continues to struggle with the costs of tobacco use in both monetary and human terms (WTO TRIPS 2011a, 2011b). The crux of the argument, which is argued to be fully consistent with TRIPS obligations, is that plain packaging is a necessary measure because the battery of existing measures is not sufficient to address the public health problems stemming from tobacco use. In a legal appraisal of the measure, Mitchell (2010: 415) notes that “it is implicit within the TRIPS Agreement itself, and especially Article 20, that a high degree of domestic regulatory autonomy shall be afforded to a Member State to enact

³The measure is designed to mitigate marketing through packaging and enhance health warnings; all manufactured tobacco products must now be sold in government-prescribed drab brown packages with the brand name only in small, plain script.

⁴In 2012, Ukraine, Honduras and the Dominican Republic requested WTO dispute settlement consultations with Australia, citing inconsistencies with the TRIPS Agreement (Articles 1, 1.1, 2.1, 3.1, 15, 16, 20 and 27), the TBT Agreement (Articles 2.1 and 2.2); and Article III:4 from GATT 1994.

measures to protect and promote public health.” Despite this legal position, the tobacco industry waged a concerted campaign in opposition to the legality of the plain packaging measure which began at least three years before Australia proposed its plain packaging legislation.⁵ Both Philip Morris International (PMI) and British American Tobacco (BAT) released documents arguing against plain packaging from scientific and legal terms. PMI claims that “generic packaging regulation expressly designed to abolish the use of these elements (i.e. logos, colors, font, trade dress and other design features) amounts to the expropriation of these intellectual properties and will expose governments to compensation claims by tobacco manufacturers” (PMI 2012). Using similar language BAT asserts that “Plain Packaging is unlawful as it would not only breach several UK, EU and international laws and agreements but would constitute a wholesale expropriation of BAT’s valuable intellectual property, requiring payment by the Government of very significant compensation” (BAT 2012: 2). These industry messages map directly onto the arguments asserted by the Ukraine, Honduras, the Dominican Republic and most recently Cuba in the WTO. These objections to the measure challenged Australia to conscientiously assert the legality of the measure when held up against the trade norms instantiated in the WTO regime. To achieve this task, Australia drew from the support of a wide range of messengers that formed a transnational network of proponents, including legal scholars, and NGO and WHO representatives.

In 2011, in TBT committee and TRIPS Council meetings that discussed the plain packaging measure in detail, trade representatives from five countries (Brazil, India, New Zealand, Norway and Uruguay) voiced direct and even enthusiastic support for Australia’s proposed measure. Uruguay, embroiled in a related investment dispute with PMI over graphic warning labels, explicitly invoked both the GATT’s public health exception, Article XX(b), and international commitments to the FCTC (WTO-TBT 2011b: paragraph 21). India’s official comments in the June 2011 TRIPS Council meeting not only cited commitments under the FCTC directly, but also referenced the scientific literature supporting plain packaging. Moreover, the Indian WTO representative pointedly cited WTO trade law, including the TRIPS Article 8 public health exception, the 2001 Doha Declaration on intellectual property and public health, and the WTO panel decision on the EC-Asbestos case (TRIPS 2011a: paragraphs 195–98), reflecting India’s longstanding commitment to flexibilities in terms of balancing intellectual property rights and the need to promote and protect health through avenues such as better access to medicines. The invocation of the legitimacy of health measures alongside the strong affirmation of the legality of such measures according to trade law is a novel development that stands in partial contrast to the *Thailand-Cigarettes* case whereby Thailand invoked the health arguments in contrast to trade norms such as non-discrimination.

The domestic issue network that has formed to support plain packaging has been widespread and deep. Led officially and at times vigorously by the Department of Health and Aging and the Attorney General’s office, the coalition of supporters has also had strong formal backing from the Preventative Health Taskforce which has strong representation from civil society

⁵Philip Morris International hired the legal firm LALive to examine the legal arguments in opposition of packaging measures, which resulted in a report produced by LALive in 2009.

and the epistemic community (Preventative Health Taskforce 2013). Health and other civil society organizations have strongly and vocally supported the legislation (Freeman et al 2008; Chapman and Freeman 2010).

In addition to the domestic network, a strong international one has also developed to support Australia's measure. Beyond the vocal support from individual countries for trade-consistent public health measures described above, the FCTC Secretariat and the WHO's Tobacco Free Initiative (TFI) have supported the Australian packaging initiative in WTO meetings. These are the most proactive recent steps taken by the Secretariat or the TFI in regard to trade. Their approach has particularly sought to demonstrate parties' precise legal obligations under the FCTC. In a brief submitted to the WTO, the FCTC Secretariat conveyed parties' legal obligations, particularly under Articles 11 (packaging and labeling) and 13 (ingredients in tobacco products) of the convention (FCTC Secretariat 2011). Similarly, the brief highlighted not only obligations under Articles 11 and 13, but also under the convention's Article 5 that address countries' commitments to exclude the tobacco industry from health policy making (WHO 2011b).

The Australia plain packaging dispute represents what has arguably developed into the largest and most consequential issue network at this policy intersection. Similar to the Canada flavorings and additives case, it involves close coordination between government health and trade officials to ensure that the legal case is sound in terms of domestic and international health and trade commitments, but it also involves other important domestic and international actors and further development of their discourse and even behavior. Many other countries' support has been strong and vocal, and two countries, New Zealand and Ireland have even announced formal plans to move forward with similar initiatives.

WTO Dispute – United States — Measures Affecting the Production and Sale of Clove Cigarettes

While the evidence presented above points to WTO member delegations beginning to articulate support for tobacco control in official meetings, until recently, official bodies within the actual WTO have remained mostly quiet on this issue since initial musings in the 1990 GATT case. But in 2011, an official WTO dispute panel ruling on a major tobacco control-trade case in which Indonesia challenged a U.S. tobacco control policy indicates that the WTO is beginning to conceptualize tobacco control measures as potentially consistent with the world trading system much more explicitly (McGrady 2011a).

In 2009, the U.S. Congress passed the Family Smoking Prevention and Tobacco Control Act (HR 1256). Section 907(a)(1)(A) of the act prohibits many additives to cigarettes, but notably does not prohibit menthol. Indonesia, a major producer of tobacco products argued that the ban was discriminatory, violating both GATT Article III:4 and TBT Article 2.1. Specifically, it argued that one of its key tobacco products and exports, clove cigarettes, was not distinguishable from cigarettes flavored with menthol. The Indonesians – supported strongly by both its domestic tobacco industry and transnational tobacco companies – also argued that the measure was not necessary to achieve a legitimate objective, such as the protection of health or life, which violates TBT Article 2.2 and cannot be justified under the public health exception in GATT Article XX(b). After the two members failed to reach an

agreement in the mandatory consultation state of the dispute settlement process, an official panel of the WTO's dispute settlement body adjudicated the dispute. In September, 2011, the panel delivered a mixed ruling that reflects the broader norms debate: the ban does violate the open trade principle of non-discrimination, but the U.S. does have the right to protect health or life in the area of tobacco control under the parameters of the TBT agreement.

On one hand, many proponents of the U.S. legislation were disappointed by the ruling. In particular, the U.S. argues that the panel mostly overlooked at least two of its key counter-arguments: because nearly a third of its smokers use mentholated cigarettes, a ban on menthol as an additive might generate problems with illicit products and place a burden on the country's healthcare system as it deals with users unable to obtain their usual product. But on the other hand, there are at least two major aspects of the decision that appear to reflect shifting norms and possibly even emerging acceptance of public health concerns from this WTO panel.

First, the panel's use of GATT XX(b) to help interpret TBT 2.2 – trade restrictiveness – is instructive about the thinking of some individuals in the dispute mechanism's official pool of members (experts who are internationally-recognized, presumably neutral authorities on international trade law). In essence, the ruling places the burden on the complainant to demonstrate that the measure is more trade restrictive than necessary. In this case, the panel ruled that Indonesia failed to demonstrate their contention of restrictiveness. In other words, the burden did not shift to the U.S. – the defendant – to justify its health-protecting measure. It is important to note that there is no formal system of legal precedent in the WTO, so panels are free to ignore or even contradict earlier decisions. The lack of formal precedent acknowledged, many WTO scholars note that panels frequently cite previous decisions, which demonstrates at least an increasingly coherent body of WTO law, both substantive and procedural (McRae 2004).

Second, for the first time, the WTO panel drew heavily on the FCTC in its deliberations and its explicit ruling – a decision made more remarkable perhaps by the fact that neither complainant nor defendant has ratified or acceded to the FCTC. In its rejection of Indonesia's claim that a ban on clove cigarettes would not deter youth smoking, it not only cited the scientific evidence but also the FCTC Partial Guidelines on Articles 9 and 10 (e.g. paragraph 7.401). The panel's decision states that the FCTC guidelines reflect both the scientific evidence and international consensus (7.414), and that banning flavored cigarettes is an explicit recommendation (7.427). The FCTC appears to have influenced the panel in its statement that the measure is complementary rather than an alternative to other tobacco control measures.

In sum, largely because of its obvious tension with basic tenets of trade law, the *U.S.-Clove Cigarettes* case did not draw the same type of broad domestic or international support that we observe in the other disputes. There was little or nothing in the way of an issue network and it was difficult to identify specific pivotal individuals. The take-home lesson, however, remains the willingness of the WTO panel as an adjudicating body not only to consider health seriously, but to cite directly the legitimacy of the FCTC. There are certainly some echoes of the GATT panel's decision from 1990, but these developments reflect further

evolution in the sophistication of its official decision-making, and the reinforcement of these evolving trade-health norms.

Brazil's ban on flavorings and additives

In some contrast to the Australian and Canadian cases above in which proponents reinforce the trade-consistent nature of the measures, in defense of its 2010 ban on tobacco flavorings and additives, Brazil, similar to the WHO, has relied more heavily on the FCTC as the foundation of its arguments. In fact, many of the opponents to Brazil's measure, including the EU, specifically expressed support for Brazil's commitment to the health objectives of the FCTC even though they challenged the specific measure on the grounds of trade law (WTO-TBT 2011b). Brazil also utilized considerable breadth of scientific evidence, particularly evidence generated by the National Cancer Institute of Brazil (INCA). Finally, a wide, mainly domestic issue network has developed in support of the ban.

Brazil's measure has faced scrutiny in TBT committee meetings (WTO-TBT 2011a, 2011c) and the arguments in opposition to the ban are familiar: it discriminates against blended tobacco products; it is too trade restrictive; and there is insufficient scientific evidence to support the claim that youth are more attracted to cigarettes with these ingredients. A significant part of Brazil's response has been to utilize the legality of the FCTC as the foundation for its regulation (WTO-TBT 2011c: paragraphs 260–61). Citing Article 1.2.1.1 of the *Partial Guidelines for Articles 9 and 10*, the Brazilian representative to the WTO pointed out that there is no justification from a public health perspective to permit ingredients that flavor or make tobacco products more attractive. Similarly, Articles 3.1.2.1 and 3.1.2.2 state that regulating the ingredients that aim to make tobacco more attractive could help to reduce prevalence. This is an argument that was challenged by the tobacco industry during the establishment of the Article 9 and 10 guidelines. British America Tobacco released a public document that asserted that “ingredients are not added to our tobacco products to make them appealing to children and there is no evidence that they (tobacco control proponents) that they have this effect” (BAT 2007). Despite this backdrop of opposition, the representative reminded the WTO members that the FCTC parties have unanimously approved these guidelines as legally binding. The following passage from the Mexican delegation, during the first TBT consultations pertaining to Brazil's measure, exemplifies the clashing norms of tobacco control and open trade: “The fact that Brazil's draft regulation was purportedly based on the WHO FCTC had no relevance as to whether the measure was in line with WTO Agreements” (WTO-TBT 2011b). This assertion is notable because it at once legitimizes the existence of the FCTC and thus the tobacco control norms, while also bringing to the surface the taken-for-granted norm of open trade in line with Finnemore and Sikkink's (1998: 892) observation that the breaking of such norms “generates disapproval or stigma”. In this case, the emerging norm of tobacco control was explicitly and systemically considered during the deliberations in the TBT committee.

Many of the WTO members that objected to Brazil's proposed legislation actually used the WHO FCTC to argue that Brazil was required to present more scientific evidence to support its measure. For example, in the first consultations within the TBT committee in 2010, the Zambian representative pointed out that the guidelines for Article 9 of the FCTC had not

been completed and thus Brazil's measure was “premature” (WTO-TBT 2011b: 4). At the same meeting, the delegate from Mexico challenged Brazil, stating that the “(FCTC) guidelines had established that measures considered necessary to regulate ingredients of tobacco products would have to be based on conclusive scientific evidence and on the experience of other countries” (WTO-TBT 2011b: 5). Many of the delegates that opposed Brazil's measure brought up the need for and Brazil's insufficient presentation of evidence linking “the banning of ingredients and the addictiveness or toxicity of tobacco products” and “that flavours caused minors to begin smoking” (WTO-TBT 2011b: 3, 5). In fact, a health activist in Brazil observed that the government had been carefully developing the content of the ban while simultaneously participating in the development of FCTC partial guidelines on Articles 9 and 10, suggesting a certain amount of coordination (personal communication, November 14, 2012).

The Brazilian WTO delegation responded to the challenge that the measure was not informed by scientific evidence by referring to a number of published studies. First, using a demographic argument, they cited a Brazilian National Institute on Cancer survey that found that 45 per cent of youth aged 13–15 consumed flavored products, a much higher proportion than adults. Second, they argued that a process for successful manufacturing of Burley tobacco products without additives has existed since 1996, which would mean that additives would thus become unnecessary. Last, they cited new scientific evidence that suggests that some additives strengthen the addictive effect of nicotine and/or exacerbate the carcinogenic effects (WTO-TBT 2011c). It is not surprising that the tobacco industry challenged such claims pertaining to the enhanced addictiveness and attractiveness of flavored tobacco products, noting that “if allegations about the health risks, addictiveness and attractiveness of tobacco ingredients had any basis, you'd expect to see a higher incidence of tobacco-related disease, lower quitting rates and more people taking up smoking in countries where traditional US-blended style cigarettes, which contain added ingredients, are popular compared to countries where Virginia- style cigarettes, which have very few or no added ingredients, are the main type of cigarettes purchased. Yet, this isn't the case” (BAT 2007). A similar argument was asserted throughout the consultations at the TBT committee, including Turkey's assertion that “these additives did not give characterizing flavor to tobacco products” (WTO-TBT 2012: 29).

In response to detractors of the ban from developing countries that cultivate tobacco leaf used in blended tobacco products (i.e. the ones that more typically require additives), the Brazil WTO delegation has also cited a broad interpretation of non-discrimination. Specifically, they refer to Brazil's large production of Burley tobacco, highlighting that the measure is not discriminatory because its numerous domestic producers will be held to identical standards as those producers exporting to Brazil. In the end, Brazil did accede to an extent by permitting the replacement of sugar lost in the manufacturing process. As of late-2012, WTO members have continued to scrutinize this measure, so it will be crucial to track the competing arguments if this dispute develops into a full WTO panel.⁶

⁶No member has yet raised the issue of Brazil's ban in 2013.

The ban was conceived and pushed forcefully by the autonomous national health surveillance and regulatory agency, Agência Nacional de Vigilância Sanitária (ANVISA), but a diverse issue network has developed in support of it. The director of a major Brazilian health NGO observed that the agency continues to have the widespread support of a network of domestic health NGOs and professional medical associations (personal communication, November 14, 2012). In governmental hearings, the agency also had international support from international health NGOs that helped to provide key scientific evidentiary justification. Also, a Canadian health official reported having discussions with Brazilian officials about Canada's experience with its ban on tobacco additives and flavorings (personal communication, November 16, 2012).

The Brazil case is particularly notable in its institutional origins with the autonomous health agency that has continued to be the ban's driving force. The agency has sought both to coordinate with trade officials and to invoke FCTC obligations clearly and emphatically. Though not on the level of the network around Australia's packaging initiative, we observe broad mobilization of a domestic issue network that includes civil society, in addition to other governments facing similar challenges.

Conclusion

The trade-related aspects of global tobacco control are clearly contentious. However, after years of uncertainty and sometimes strong conflict between trade and public health, a global discourse seeking to integrate the two norms more coherently continues to evolve both informally among the two communities, and formally, particularly in the different venues of the WTO. The five cases presented above provide tangible examples of how the discourse of a wide range of actors seeking to find logical ways to integrate the norms of health and open trade is changing. To a limited extent, we are also beginning to see changes in actual policy behaviors as actors become more assertive in the protection of the right to regulate health.

Undoubtedly, the trade and tobacco control norms discourse has often been highly polarized. The public health community has tended to pit trade against tobacco control, with an air of skepticism about whether health norms could prevail in an environment where trade norms have historically dominated (e.g. Callard et al. 2001). However, we have demonstrated that tobacco control norms have not only evolved in the broader trade policy discourse, but have been used directly to consider disputes and issues regarding tobacco trade-related regulation and legislation by those defending measures, those challenging them and those attempting to sort out the complexities, including through formal international-level adjudication.

Both the challenges to open trade and the efforts to integrate these policies in tension with tobacco control are no doubt part of a broader shift across multiple policy areas seeking similar balance. The WTO panel ruling in the *U.S.-Clove Cigarettes* case demonstrates this complexity indirectly because it considers explicitly other relevant trade cases – e.g. *EC-Biotech* and *EC-Asbestos* – that also address the protection of health or life and the environment (WTO 2011). Though distinct in some ways, the tobacco control-trade policy nexus is not isolated, but rather, part of a broader shift as countries consider the challenges of global governance generally, and how to integrate norms that demonstrate inherent

tensions more specifically. For example, the Bangkok Charter for Health Promotion in a Globalized World, adopted by WHO member states, specifically notes that “to manage the challenges of globalization, policy must be coherent across all levels of government, United Nations Bodies, and other organizations, including the private sector” (WHO 2005). It appears that the WTO dispute settlement system has become a “policy space” for global intersectoral policymaking (Stone 2008). Policy spaces emerge when different state and non-state actors converge to address a particular policy issue. Although the intended objective of dispute settlement in the WTO forum is to negotiate solutions to the misalignment of domestic policy with international trade rules, the process itself has enlisted different state and non-state actors in the clarification of apparently conflicting norms. This transnational exercise is noteworthy as both a norms creator and propagator that influences domestic politics, and as a forum where domestic politics is confronted by transnational issue networks, policy entrepreneurs and non-state interest groups.

Despite the increasing prominence of health norms in the trade arena, the use of economic and trade rationale by many countries against public health is a challenge to its development as a sustainable norm, particularly given that efforts to improve tobacco control will only continue to intersect with trade rules. Many of the countries that have raised arguments in support of less trade-restrictive tobacco control legislation in the above cases are those whose economies are deeply rooted in global tobacco production, controlled, for the most part, by transnational tobacco corporations. For example, PMI currently controls the majority of the tobacco production in the Dominican Republic (Labonté et al. 2011), a country that has been among the most vocal opponents of Canada's Bill C-32 and Australia's plain packaging legislation. Not surprisingly perhaps, PMI is the same corporation that has filed suit under the auspices of bilateral investment treaties against Uruguay (2010) and Australia (2011) for their tobacco packaging legislation (Lencucha 2010; Voon and Mitchell 2011), wherein the legal process generates new challenges by giving private firms legal standing against national governments in the setting of international arbitration.

The norms tension is particularly salient given its development implications for lower and middle-income countries, where tobacco consumption places a 200 billion dollar health burden on countries beyond the monetary benefits of tobacco production and sales (Jha & Chaloupka 1999). In 2013, 12 countries – some of them low- and middle-income countries – in the Pacific region were continuing to negotiate a new trade agreement, the Trans-Pacific Partnership, that would comprise countries that generate more than a quarter of the world economy's output. Health issues do not appear to have been prominent in the typically opaque discussions, and negotiators, which prominently include the USTR, have largely excluded health-focused actors from the process (Fooks and Gilmore 2013). Lessons from this research suggest that health actors need to buttress the network of potential messengers and fine-tune the message such that it reaches the negotiators more effectively. For their part, trade negotiators need: better education on health issues, to consider more how to incorporate protection of health effectively into the development of economic agreements, and to understand how central health is to the overall prosperity of nations.

Resolving the tensions between tobacco control and economic policymaking is undoubtedly important, but it represents only one important facet of broader strategy as proponents of

healthy societies determine how they reach their goals within an economic system striving to engender prosperity, mainly through economic openness. We are already observing similar dynamics as proponents of environmental protection and access to medicines seek outcomes similar to their tobacco control colleagues. Similarly, in the near future, we anticipate that issues related to alcohol, diet and physical activity will encounter circumstances that will closely mirror the dynamics examined here. Tobacco control offers a useful lens and a powerful set of lessons for broader proactive health policy making in the complex context of global governance. Though the recent changes have been mostly positive, there remains considerable space for more consideration of public health within trade and other economic policy areas.

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