The Trans-Pacific Partnership Agreement: A Test for Health Diplomacy

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The Trans-Pacific Partnership Agreement: A Test For Health Diplomacy

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Abstract
Against the background of stalled negotiations in the World Trade Organization (WTO), there has been a proliferation of bilateral and regional trade agreements. Most of these contain provisions which go beyond existing WTO agreements in the protection of intellectual property (IP), and raise concerns about the ability of low and middle-income countries to provide affordable drugs for their populations. An extreme case is the Trans-Pacific Partnership Agreement (TPPA), now under negotiation among eleven countries. Competing interests within and among countries, evolving alliances and economic ties, and external factors present a challenge for health diplomacy at the intersection of health and trade. With the emergence of new economic power centres, low and middle-income countries have wider choice for trade partnerships and do not have to accept agreements that are incompatible with their policy objectives. The situation calls for a more sophisticated and inclusive style of health diplomacy than we have seen up to now.

Here we will review the background and contents of the TPPA, and then examine choices facing Thailand as it considers joining TPPA negotiations.

Background
Prior to the introduction of the World Trade Organization’s (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in 1995, international trade agreements aimed at reducing tariffs, taxes and import quotas. TRIPS went further to require WTO members to adopt intellectual property (IP) protections similar to those in the advanced economies of western industrialized countries—for example, patent protection for all products and processes, with a minimum duration

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of 20 years. Low and middle-income countries have resisted efforts by developed countries to extract further trade concessions through the Doha Round of multilateral trade negotiations at the WTO, and initiatives for trade liberalization are now negotiated outside the WTO in the form of regional and bilateral free trade agreements (FTAs). More than 300 FTAs are now in force, with many more under negotiation (Baldwin & Jaimovich, 2012; Krishna, Mansfield, & Mathis, 2012). FTAs have introduced intellectual property protections beyond those in the TRIPS agreement. Some of these are broader criteria for patentability, restrictions on opposition to patents, extension of patent duration beyond 20 years and restriction of use of existing test data for licensing of generics (data exclusivity) (Joint United Nations Programme on HIV/AIDS (UNAIDS), 2012).

There is little doubt that extensive and unprecedented intellectual property protections introduced in FTAs can have a significant negative impact on price and availability of medicines. For example, delayed entry of generic drugs into the market due to increased intellectual property protection is estimated to have cost Jordan’s private consumers approximately US$18 million (14 percent of total private expenditure on medicines) more in 2004 (Abbott et al., 2012). Similar estimates have been reported for Colombia (Gamba, 2006).

A joint United Nations Development Programme (UNDP) and Joint United Nations Programme on HIV/AIDS (UNAIDS) policy statement issued in 2012 recommends that countries “should avoid entering into FTAs that contain TRIPS-plus obligations that can impact on pharmaceuticals price or availability” (Joint United Nations Programme on HIV/AIDS, 2012).

Health diplomacy is especially challenged at the intersection of trade and health because of the multiplicity of partners; differing and sometimes incompatible understanding of the issues; and competing economic, social and political objectives.

**The Trans-Pacific Partnership Agreement (TPPA)**

Recent FTAs go further to protect intellectual property and the interests of investors in all sectors, including pharmaceuticals. An example is the Trans-Pacific Partnership Agreement (TPPA), now in negotiation among eleven countries (United States, Australia, Brunei, Chile, Malaysia, New Zealand, Peru, Singapore, Vietnam, Mexico and Canada). Japan is also widely expected to join the TPPA negotiations. The United States has emerged as the leading proponent of the TPPA, and proposed several primary negotiating texts.

TPPA negotiations are carried out in secret, with even members of the US Congress not always informed (InfoJustice, 2012a). Analysis must therefore rely on leaked documents (InfoJustice, 2012b; Knowledge Ecology International, 2012; Public Knowledge, 2012). While confidentiality is seen by some trade officials as necessary for an effective negotiating process, health sector policy makers, elected political representatives and consumers rarely participate in trade negotiations. The open negotiation of the WTO agreements also belies the argument that trade agreements may only be negotiated effectively in secret.

Based on available documents, several provisions of the US proposals for the TPPA raise concerns for health. Some of these are:

**Intellectual property protection.** Standards for patentability are lower than those in the TRIPS agreement. TRIPS leaves flexibility for determining patentability standards. However, the US proposals require that countries allow patents for new uses of existing products and for minor chemical modifications of known products. This conflicts with recommendations by international bodies for
higher, not lower, patentability standards (Commission on Intellectual Property Rights, Innovation and Public Health [CIPIH], 2006; UNDP, 2010). Pre-grant opposition by civil society groups, competitors or others to a patent application that has proven an important opportunity to prevent inappropriate patents is forbidden under the version of TPPA currently under negotiation. Notably, public interest groups in India have used both strategies to prevent the “evergreening” of patents on key HIV, hepatitis C and cancer medicines. Another area of concern is enforcement, including border measures that appear to allow seizure of generic medicines of assured quality, when they allegedly infringe trademarks in a transit country, even when they are lawful in sending and receiving countries. For example, seizures of generic medicines under similar provisions by the European Union (EU) delayed the delivery of generic antibiotics from India to Vanuatu and attracted global outrage (Health Action International, 2009).

Measures for protection of foreign investors. In the TPPA, “investment” is defined extremely broadly, going well beyond “real” property and covering any asset owned or controlled directly or indirectly by an investor, including a commitment of capital or other resources, expectation of gain or profit, or assumption of risk. Thus, government actions that allegedly might reduce the value of an investment or even the expectation of profits could be considered as “expropriation.” For example, this might include allowing a competing product, such as a generic version of a drug, to enter the market. Changes to IP laws and the use of TRIPS flexibilities could potentially be interpreted as actions that interfered with investors’ reasonable expectations of profits, and the TPPA proposals allow investors to sue for compensation in such situations, although an exception is made in the case of a compulsory licence. Moreover, such disputes would be handled through an Investor-State Dispute Settlement (ISDS) procedure. This remarkable provision means that investor-country disputes and settlements could be decided completely outside of the country’s judicial process, a significant infringement of national sovereignty.

Restrictions on national policy for pricing and reimbursement of pharmaceuticals. A Health Care Transparency Annex of the draft TPPA deals with pricing of pharmaceutical products, and would limit a country’s policy options for containing the cost of medicines. For instance, provisions in this annex may interfere with a country’s ability to rely on international reference prices as a benchmark to determine reasonable reimbursement rates.

A Test for Health Diplomacy

Thailand’s position on the TPPA is instructive. Although Thailand has expressed interest in joining the TPPA, Thailand must balance the TPPA against other agreements in force or in negotiation, as well as against external diplomatic considerations (Yoon, 2012). Thailand has active FTAs with China, Japan, Peru, Chile, Australia and New Zealand. Agreements are also under negotiation with India, the EU, ASEAN (the ASEAN Economic Community) and the 16-country Regional Comprehensive Economic Partnership (RCEP), heavily promoted by China. The RCEP includes countries responsible for 40 percent of world trade: 11 countries of the ASEAN group along with Japan, Australia, New Zealand, South Korea and India. The United States is conspicuously absent from the RCEP, perhaps viewing it as an alternative to the US-promoted TPPA. RCEP is considerably more flexible than TPPA, more in line with TRIPS, and free of “TRIPS-plus” provisions (Antkiewicz & Whalley, 2005; Hiebert & Hanlon, 2012). A coercive approach to trade negotiation by the major industrial powers may backfire, considering that low and middle-income countries now have strategic and trade alternatives.
In the Thai experience, industrialized country economic power, when used coercively, does not pose as great a threat as previously assumed. After Thailand issued government-use licences for seven patented medicines between 2006 and 2008, the United States retaliated by withdrawing duty-free access for several high-value Thai exports. Over the next five years, Thailand experienced a reduction of exports to the United States, but overall exports increased substantially, primarily to Asian countries including China. In effect, this was a de-coupling from the US market. Fears of a disastrous effect of US retaliation were not realized (Yamabhai, Adun, Sripen, Kakanang, & Yot, 2011).

Diplomatic concerns for Thailand go beyond trade agreements, as the country seeks to balance a long-standing historic and military relationship with the United States against growing economic ties with China and countries of the Mekong region. An example is the Chinese-supported rapid rail system for the Mekong region, which will link China, Thailand, Singapore, Malaysia, Cambodia, Viet Nam, Myanmar and Laos (China Daily, 2012; Pushpanathan, 2012).

If Thailand does join the TPPA negotiations, it may receive some support from Australia and New Zealand as Thailand seeks to protect its own highly praised programme of universal access to health care. These countries’ subsidized medicine schemes are also threatened by the TPPA, and on these issues, the Australian and New Zealand positions are closer to those of low and middle-income countries than to the US position, raising the interesting possibility of realignments in the negotiating process (Ferguson & Vaughn, 2011).

Conclusion

Health protections, already fragile under existing agreements including the WTO’s TRIPS, are under increased threat from new trade initiatives like the Trans-Pacific Partnership Agreement. A more assertive approach for health diplomacy by low and middle-income countries is needed, beginning with early participation by national health policy makers and civil society in trade negotiations. Thailand’s experience shows that fears of economic retaliation when a country takes policy action to protect public health may be unfounded.

Health concerns cannot remain an afterthought in trade negotiations. Health diplomacy’s successes in other settings (for example, the UN’s Millennium Development Goals) must be matched in the trade sector, recognizing that countries have alternatives to trade agreements which threaten the health of their populations.
References


