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International Investment Law and Non-Communicable Diseases Prevention: An Introduction

Amandine Garde and Jure Zrilič*

Abstract

It is increasingly acknowledged that non-communicable diseases (NCDs) create immense human and economic costs, disproportionately affecting developing countries. This article, which serves as an introduction to this Special Issue on international investment law and NCD prevention, outlines the international framework for the prevention of NCDs, noting the more advanced development of tobacco control policies compared to policies relating to other NCD risk factors, such as unhealthy diets and alcohol consumption. Drawing on the *Philip Morris v Uruguay* case, the article explains how international investment law and NCD prevention interact and the problems this interaction may raise for States willing to adopt robust NCD prevention strategies involving the regulation of the tobacco, alcohol and food industries. It concludes by introducing other contributions in this Special Issue and by highlighting the need to build legal expertise in this area.

Keywords non-communicable diseases (NCDs), tobacco, alcohol, unhealthy food, international investment law, investment treaties, investor-State arbitration

* Professor Amandine Garde, University of Liverpool, School of Law and Social Justice, Director of the Law & NCD Unit, e-mail: agarde@liverpool.ac.uk; Dr Jure Zrilič, University of Liverpool, School of Law and Social Justice, e-mail: j.zrilic@liverpool.ac.uk. We would like to thank the contributors to this Special Issue without whom it would not have been possible. We would also like to thank other colleagues who also participated in the initial conference that we organized in London on 10 and 11 May 2018 and which allowed for vivid and open debates. This event was supported by a grant of the Research Development Fund of the School of Law and Social Justice at the University of Liverpool, for which we are sincerely grateful. We are particularly grateful to our colleagues and friends from the Law & NCD Unit who have a wealth of expertise in international economic law and have been extremely supportive throughout this project: Daniel Behn, Joshua Curtis, Gregory Messenger and Mavluda Sattorova. We are also indebted to Benn McGrady at the WHO for his interest in our work and the insights that the Law & NCD has gained through the legal capacity building work it has undertaken with the WHO over the years. Last but not least, we are grateful to Stephan Schill, Hélène Ruiz Fabri and their colleagues at the Journal of World Investment & Trade for offering us the opportunity to publish this Special Issue in a prestigious journal.

1 The Growing Prevalence of Non-Communicable Diseases as a Pressing Global Health Challenge

On 28 and 29 June 2019, the Leaders of the G20 met in Japan to make united efforts to address major global economic challenges. In their Declaration, they specifically noted that 'health is a prerequisite for sustainable and inclusive economic growth' and undertook to 'promote healthy and active ageing through policy measures to address health promotion prevention and control communicable and non-communicable diseases.'[1]

The four main groups of non-communicable diseases (NCDs)—cancers, cardiovascular diseases, chronic respiratory diseases, and diabetes—are the most common cause of death and disability worldwide, accounting for 71% of all deaths and more than three out of four years lived with a disability.[2] The human and economic cost of NCDs is immense: it affects the health of individuals, it significantly increases the cost to national health services and it entails broader societal costs such as lost productivity and absenteeism related to ill-health, whilst increasing health inequities.[3]

The rapid growth of NCDs also threatens sustainable development, as the burden of NCDs continues to rise disproportionately in developing countries: every year 15 million people between the ages of 30 and 69 die from NCDs, and 86% of these premature deaths occur in developing countries.[4] It is therefore not surprising that the Sustainable Development Goals (SDGs) explicitly recognize the importance of preventing NCDs. In particular, SDG 3 calls on 'all countries and all stakeholders' to 'ensure healthy lives and promote well-being for all at all ages' and urges them, by 2030, to: reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and wellbeing; and strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks. SDG 3 also refers specifically to the imperative of reducing alcohol and tobacco consumption, whilst SDG 2, focusing on all forms of nutrition,

[1] G20 Osaka Leaders' Declaration of 28–29 June 2019, para 31.
[2] UN General Assembly Resolution 73/2 of 10 October 2018 (A/73/L.2) adopting the Political declaration of the third high-level meeting of the General Assembly on the prevention and control of NCDs, following the High-level meeting held on 27 September 2018 to undertake a comprehensive review of the prevention and control of NCDs.
[3] In 2011, the Harvard School of Public Health and the World Economic Forum estimated that on top of the social and psychological burdens of chronic disease, the cumulative loss to the global economy could reach USD 47 trillion by 2030 if things remained as they were: *The Global Economic Burden of Non-communicable Diseases*, Geneva: World Economic Forum, September 2011.
[4] WHO, 'Noncommunicable Diseases: Key facts', WHO, Geneva (1 June 2018) <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases> accessed 18 January 2020.

urges them to 'end hunger, achieve food security and improved nutrition and promote sustainable agriculture'.[5]

The health burden associated with increasing rates of NCDs gained international prominence following the first United Nations (UN) High Level Meeting on Prevention and Control of NCDs held in September 2011.[6] The meeting was of particular significance, as it was the first time that major NCD risk factors were considered together by the international community in such a prominent way. It subsequently led to a series of global declarations, action plans and recommendations, as well as the establishment of commissions, working groups and taskforces committed to addressing NCDs as a growing public health concern and acknowledging the primary role and responsibility of States.[7]

Many NCDs are eminently preventable by addressing their central underlying risk factors: unhealthy diets, physical inactivity, tobacco and alcohol use. Evidence has accumulated over the last 15 years of what States should do to turn the places in which we live into health enabling environments. The World Health Organization (WHO) Global Action Plan for the prevention and control of NCDs 2013–2020 provides Member States, international partners and the WHO with various policy options which, when implemented collectively, would reduce the impact of the main NCD risk factors. These options include the imposition of information schemes (e.g. product labelling), pricing policies (e.g. excise taxes), marketing restrictions, and product reformulation.[8] Importantly, the financial investment to alleviate the burden of NCDs is comparatively small, insofar as many of the WHO's recommended measures offer a good financial return on investment, as well as health and social benefits.[9]

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[5] UN General Assembly, 'Transforming Our World: The 2030 Agenda for Sustainable Development', A/RES/70/1, New York, 25 September 2015.

[6] UN General Assembly, 'Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases', A/66/L.1, United Nations, 16 September 2011.

[7] For an overview, see Amandine Garde, 'Law and Non-Communicable Diseases Prevention: Maximizing Opportunities by Understanding Constraints', in Gian L Burci and Brigit Toebes (eds), *Research Handbook on Global Health Law* (Edward Elgar 2018) ch 13.

[8] Resolution WHA 66.10. In 2017, the WHO Director-General submitted a report on the progress achieved in the implementation of these commitments to the UN General Assembly, in preparation for its comprehensive review, in September 2018, at its third High Level meeting devoted to the progress achieved in controlling and prevention NCDs.

[9] In 2011, the WHO and the World Economic Forum estimated that, if interventions remained static and NCD rates continued to increase as populations grow and age, economic losses in low-and-medium income countries due to the four main NCDs would surpass USD 7 trillion over the period 2011–2025, thus amounting to an average of nearly USD 500 billion per year, equivalent to approximately 4% of these countries' annual output: WHO and World Economic Forum, 'From Burden to "Best Buys": Reducing the Economic Impact of Non-communicable Diseases in Low- and Middle-income Countries', WHO, Geneva, 18 September 2011, 3. For details on the comparative cost of scaling up interventions, see WHO, 'The Global Economic Burden of NCDs and Scaling Up Action against Noncommunicable Diseases: How much will it cost?', WHO, Geneva, September 2011, 17–29.

Several sectoral policy instruments have been developed that complement the WHO's Global Action Plan and other transversal political declarations, strategies and action plans that draw attention to the importance of addressing NCDs.[10] Most notable is the Framework Convention on Tobacco Control (FCTC), the first and—to date—the only legally binding global public health treaty negotiated under the auspices of the WHO.[11] It promotes a comprehensive approach to tobacco control, calling on its 181 Parties to adopt measures intended to address both the demand for (Articles 6 to 14) and the supply of (Articles 15 to 17 and the additional protocol) tobacco products. These measures, which constitute minimum requirements,[12] are comprised of price measures (particularly taxation) and other measures intended to reduce the demand for tobacco (such as tobacco packaging, labelling and marketing restrictions). They also include core supply reduction measures, covering in particular illicit trade in tobacco products and the sales of tobacco to and by minors. The FCTC therefore recognizes that only a coordinated multisectoral approach can effectively prevent smoking-related NCDs.[13] Moreover, the FCTC is supplemented by a range of evidence-based guidelines and policy options and recommendations which allow for its dynamic interpretation, facilitating the adaptation by States of their regulatory frameworks to the latest available evidence. Even though they are not legally binding, the Guidelines have been adopted by consensus and are based on the best available scientific evidence as well as the experience of the Parties to the FCTC. Furthermore, they are intended to have a decisive influence on the content of the rules adopted in the area under consideration. The FCTC's full implementation is integral to the commitments States have made to achieving a reduction in premature deaths from NCDs, including a 30 per cent relative reduction in the prevalence of tobacco use in persons aged 15 years and over by 2025.[14]

As far as other NCD risk factors are concerned, there is no similar, legally binding global treaty on which national and regional policies on healthy diets, physical activity and

[10] See, for example, the Global Strategy for Women's, Children's and Adolescents' Health 2016–2030 which 'envisions a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies': Resolution WHA 69.2; and the Global Strategy and Action Plan on Ageing and Health 2016–2020, which pursues the objective of maximizing healthy ageing in advance of the Decade of Healthy Ageing 2020–2030: Resolution WHA 69.3.

[11] WHO Framework Convention on Tobacco Control (opened for signature 16 June 2003, entered into force 27 February 2005) 2302 UNTS 166.

[12] FCTC, art 2.1.

[13] FCTC, art 4.2: 'Strong political commitment is necessary to develop and support, at the national, regional and international levels, comprehensive multisectoral measures and coordinated responses'.

[14] Resolution WHA 66.10 Adopting the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020, and para 36.

alcohol control rest, though proposals for such a broad global convention have been made.[15] Rather, the WHO has developed a set of global strategies,[16] action plans, recommendations[17] and other policy documents[18] which have been welcomed, endorsed or approved unanimously by WHO Member States which gather annually in Geneva at the World Health Assembly, the decision-making body of the WHO. Collectively, these documents represent the developing global consensus on the measures required to adequately address the health burden associated with NCDs. Nevertheless, their implementation requires strong political will and leadership which have tended to be less consistent than in relation to tobacco control.[19] This is highly problematic in light of the harm caused by the consumption of unhealthy diets and alcohol, and particularly in light of growing childhood obesity rates which have increased from 4% in 1975 to about 18% in 2016.[20] It is hoped that the UN Decade of Action on Nutrition 2016–2025 can help galvanize political will and promote a closer and more effective UN interagency collaboration.[21]

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[15] In May 2014, World Obesity Federation and Consumers International published a set of recommendations towards a global convention to protect and promote healthy diets: <https://s3.eu-central-1.amazonaws.com/ps-wof-web-dev/site_media/uploads/Convention_on_Healthy_Diets_FINAL.pdf> accessed 1 March 2020. This idea has been made more recently by Boyd Swinburn and colleagues: Boyd Swinburn et al, *The Global Syndemic of Obesity, Undernutrition, and Climate Change: The Lancet Commission report*, The Lancet, 27 January 2019. On alcohol, see Andrew Mitchell and Jessica Casben, 'Trade Law and Alcohol Regulation: What Role for a Global Alcohol Marketing Code?' (2017) 112 Addiction 109.

[16] See in particular the Global Strategy for Infant and Young Child Feeding (2002): Resolution WHA 55.25; the Global Strategy on Diet, Physical Activity and Health (2004): Resolution WHA 57.17; the Global Strategy to Reduce the Harmful Use of Alcohol (2010): Resolution WHA 63.13; and the Global Action Plan for Physical Activity 2018–2030 (2018): Resolution WHA 71.18.

[17] See in particular the International Code of Marketing of Breast-milk Substitutes (Resolution WHA 34.22) and subsequent relevant WHA resolutions; and the set of WHO recommendations on the marketing of foods and non-alcoholic beverages to children: Resolution WHA 63.14.

[18] See in particular the final report of the WHO Commission on Ending Childhood Obesity: Resolution WHA 69.8.

[19] Part of the explanation probably lies in the relative novelty of the problem associated with unhealthy diets: smoking has been on the regulatory agenda of States and international organizations for many more decades than healthy nutrition. Part of the explanation may also lie in the fact that, whilst all cigarettes and tobacco products are harmful for public health, in the field of nutrition it is necessary to distinguish between healthy and unhealthy food: child obesity and related NCDs result from the excessive consumption of *unhealthy* food and beverages, which unavoidably complicates the development and implementation of policy interventions that are both effective and necessary.

[20] 41 million children under the age of five were overweight or obese in 2016. Over 340 million children and adolescents aged 5–19 were overweight or obese in 2016. WHO, 'Obesity and Overweight: Key Facts and Figures', WHO, Geneva (16 February 2018) <https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight> accessed 18 January 2020.

[21] In 2013, the UN Inter Agency Task Force on NCDs was established, with the WHO as its lead agency, to 'raise the priority accorded to the prevention and control of NCDs in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy'. The Task Force 'coordinates the activities of relevant UN organizations and other inter-governmental organizations to support governments to meet high-level commitments to respond to NCD epidemics worldwide': WHO, 'Terms of Reference for the UN Interagency Task Force on the Prevention and Control of Noncommunicable Diseases', WHO, Geneva, 2015, 12. On the work of UN agencies on child obesity and the need for more collaboration, see Wenche Barth Eide and Asbjørn Eide, 'Can the United Nations System be Mobilized to Promote Human Rights-Based Approaches in Preventing and Ending Childhood Obesity?' in Amandine Garde, Joshua Curtis and Olivier

The evidence and the high-level policy response has established that NCD trends will only be reversed if States adopt the laws and regulations necessary to promote our ability to reduce our consumption of tobacco, alcohol and unhealthy food in favour of healthier food and beverages. In particular, the 2018 UN Political Declaration urges States to:

> promote and implement policy, legislative and regulatory measures, including fiscal measures as appropriate, aiming at minimizing the impact of the main risk factors for non-communicable diseases, and promote healthy diets and lifestyles.[22]

To build and protect health promoting environments, States must address the underlying social, economic and environmental determinants of NCDs and the impact of economic, commercial and market factors.[23]

This imperative is reinforced by the growing recognition that increasing rates of NCDs, and particularly childhood obesity, should be envisaged as a human rights concern.[24] Individuals hold a range of human rights, not least the right to the enjoyment of the highest attainable standard of health, which States have a duty to respect, protect and fulfil.[25] In particular, it is increasingly accepted that, even though the Convention on the Rights of the Child and other international human rights instruments do not explicitly address NCDs, their dynamic interpretation mandates States to regulate the tobacco, alcohol and food industries effectively to limit the harm associated with the consumption of tobacco, alcohol and unhealthy diets—thus indirectly granting some normative force to relevant WHO policy documents and increasing the accountability to which States should be subjected for their failure to implement them.[26] As a result, the 2018 UN Political Declaration has highlighted that States should be in the driving seat and:

> [t]ake the necessary measures to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health across the life course, in respecting human rights obligations and addressing the specific health needs of

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De Schutter (eds), *Ending Childhood Obesity: A Challenge at the Crossroads of International Human Rights and Economic Law* (Edward Elgar Publishing, forthcoming, 2020).

[22] Resolution 73/2 (n 2) para 21.

[23] To implement these actions, the international community has committed 'to act in unity to create a just and prosperous world where all people can exercise their rights and have equal opportunities to live healthy lives in a world free of the avoidable burden of non-communicable diseases'. Ibid para 49.

[24] See in particular the WHO Global Action Plan on the prevention and control of NCDs for 2013-2020: Resolution WHA 66.10, and the final report of the WHO Commission on Ending Childhood Obesity: Resolution WHA 69.8.

[25] Beyond the right to health, one should also consider the right to adequate nutritious food, the right to life, the right of the child to have his/her bests interests upheld as a primary consideration in all policies concerning them…

[26] See in particular Unicef, *A Child Rights Based Approach to Food Marketing: A Guide for Policy Makers*, Unicef, Geneva, April 2018; and Unicef and UN Special Rapporteur on the Right to Food, *Protecting Children's Right to a Healthy Food Environment*, Unicef and UN Human Rights Council, Geneva, November 2019.

children, women, older persons, persons with disabilities and others who are more vulnerable to non-communicable diseases.[27]

However, progress towards the objectives set to reduce the prevalence of NCDs and, in particular to halt the rise in child obesity, has been extremely slow overall. As the UN General Assembly noted in September 2018, action to realize the commitments made for the prevention and control of NCDs is inadequate: 'The world has yet to fulfil its promise of implementing, at all levels, measures to reduce the risk of premature death and disability from [NCDs].'[28]

2 The Tobacco, Alcohol and Food Industries as Major Contributors to the Growing Prevalence of Non-Communicable Diseases

Part of the problem stems from the systematic opposition that major industry actors either have mounted, or are likely to mount, against regulation: 'Big Tobacco', 'Big Alcohol' and 'Big Food' operate at all levels (local, national, regional and global) and have major means at their disposal to influence the policy process.[29] The food, alcohol and tobacco industries are highly

[27] Resolution 73/2 (n 2) para 28. There is a growing literature on the role of human rights law in preventing NCDs. See in particular: Carolyn Dresler and Stephen Marks, 'The Emerging Human Right to Tobacco Control' (2006) 28 Human Rights Quarterly 599; Melissa E Crow, 'Smokescreen and State Responsibility: Using Human Rights Strategies to Promote Global Tobacco Control' (2004) 29 Yale Journal of International Law 209; John Tobin, 'Beyond the Supermarket Shelf: Using a Rights Based Approach to Address Children's Health Needs' (2006) 14 International Journal of Children's Rights 275; Amandine Garde, 'Advertising Regulation and the Protection of Children Consumers in the European Union: In the Best Interest of … Commercial Operators?' (2011) 19 International Journal of Children's Rights 523; Oscar A Cabrera and Lawrence O Gostin, 'Human Rights and the Framework Convention on Tobacco Control: Mutually Reinforcing Systems' (2011) 7 International Journal of Law in Context 285; Lize Mills, 'Selling Happiness in a Meal: Serving the Best Interests of the Child at Breakfast, Lunch and Supper' (2012) 20 International Journal of Children's Rights 624; Lize Mills, *Considering the Best Interests of the Child When Marketing Food to Children: An Analysis of the South African Regulatory Framework* (2016) LLD thesis, Stellenbosch University; Katharina Ó Cathaoir, 'Childhood Obesity and the Right to Health' (2016) 18 Health and Human Rights Journal 249; Katharina Ó Cathaoir, *A Children's Rights Approach to Obesogenic Marketing* (2017) PhD thesis (mimeo), University of Copenhagen; Amandine Garde et al, 'For A Children's Rights Approach to Obesity Prevention: The Key Role of Effective Implementation of the WHO Recommendations' (2017) 8 European Journal of Risk Regulation 327; Brigit Toebes et al, 'A Missing Voice: The Human Rights of Children to a Tobacco-Free Environment' (2018) 27 Tobacco Control 3.

[28] Resolution 73/2 (n 2) para 4.

[29] The tactics used by the tobacco, alcohol and food industries are increasingly well documented. See, for example, the excellent *Tobacco Tactics* site run by Bath University: <http://www.tobaccotactics.org> accessed 18 January 2020; Tobacco Free Initiative, *Watching and Countering the Industry*: <http://www.who.int/tobacco/industry/en/> accessed 18 January 2020; *Tobacco Industry Interference with Tobacco Control*, WHO, Geneva, 2009; Kelly Brownell and Kenneth Warner, 'The Perils of Ignoring History: Big Tobacco Played Dirty And Million Died. How Similar is Big Food?' (2009) 87(1) The Milbank Quarterly 259; Lori Dorfman et al, 'Soda and Tobacco Industry Corporate Social Responsibility Campaigns: How Do They Compare?' (2012) 9 PLoS Med 1241; Rob Moodie et al, 'Profits and Pandemics: Prevention of Harmful Effects of Tobacco, Alcohol, and Ultra-Processed Food and Drink Industries' (2013) 381 The Lancet 670; Sarah L Steele et al 'The Role of Public Law-Based Litigation in Tobacco Companies' Strategies in High-Income, FCTC Ratifying Countries, 2004–14' (2016) 38 Journal of Public Health 516; Marion Nestle, *Soda Politics: Taking on Big Soda (and Winning)* (OUP 2015); Rob Moodie, 'What Public Health Practitioners Need to Know About Unhealthy Industry Tactics' (2017) 107 American Journal of Public Health 1047.

concentrated, and increasingly so, due to recent mergers within these industries. States are dealing with multinational corporations (MNCs) whose global turnover may be superior to their gross domestic product. This economic power both stems from, and increases the ability of, these industries to operate at all levels, from the very local to the global, and to benefit significantly from the opportunities that globalization and economic liberalization offer.[30] Trade liberalization in particular has greatly increased foreign direct investment (FDI) in the tobacco, alcohol and food industries, and there is increasing evidence that such liberalization has had negative consequences for public health in that it has promoted the trade and, indirectly, the consumption of commodities directly implicated in growing rates of NCDs worldwide. In particular, several studies have established a link between trade in tobacco products and increased demand for such products,[31] and between trade liberalization and increasing rates of obesity[32] and the expansion of processed food markets in developing countries,[33] as facilitated by intensive marketing investments.[34]

Significant attention has recently been focused on obesity and related NCDs in Small Island Developing States (SIDs). For example, the Caribbean region is highly dependent on food imports to meet its needs.[35] As imports of processed and semi-processed goods have

[30] For a fuller discussion of the economic power of agri-food MNCs, see the introductory chapter in Garde et al, *Ending Childhood Obesity* (n 21); see also Fabrice Etilé and Lisa Oberländer 'The Economics of Diet and Obesity: Understanding the Global Trends', Oxford Research Encyclopedia of Economics and Finance, March 2019, DOI: 10.1093/acrefore/9780190625979.013.19.

[31] See in particular Frank Chaloupka and Adit Laixuthai, 'U.S. Trade Policy and Cigarette Smoking in Asia', NBER Working Paper Series, Working Paper 5543, April 1996; Douglas Bettcher et al, *Confronting the Tobacco Epidemic in an Era of Trade Liberalization* (WHO Commission on Macroeconomics and Health 2001); and, more recently, Benn McGrady, *Confronting the Tobacco Epidemic in a New Area of Trade and Investment Liberalization* (WHO 2012).

[32] See in particular Anne Marie Thow and Wendy Snowdon, 'The Effect of Trade and Trade Policy on Diet and Health in the Pacific Islands' in Corinna Hawkes et al (eds), *Trade, Food, Diet and Health: Perspectives and Policy Options* (Wiley Blackwell 2010) 147–68. For an Asian perspective on the impact of trade and investment liberalization on NCD prevalence, see Phillip Baker et al, 'Trade and Investment Liberalization and Asia's Non-Communicable Disease Epidemic: A Synthesis of Data and Existing Literature' (2014) 10(1) Globalization and Health 66; and Ashley Schram et al, 'The Role of Trade and Investment Liberalization and the Sugar-Sweetened Carbonated Beverages Market: A Natural Experiment Contrasting Vietnam and the Philippines' (2015) 11(1) Globalization and Health 41. On Peru and Bolivia, see Phillip Baker et al, 'Trade and Investment Liberalization, Food Systems Change and Highly Processed Food Consumption: a Natural Experiment Contrasting the Soft-Drink Markets of Peru and Bolivia' (2016) 12(1) Globalization and Health 24.

[33] Ane Marie Thow and Corinna Hawkes, 'The Implications of Trade Liberalization for Diet and Health: A Case Study from Central America' (2009) 5 Global Health. As Etilé and Oberländer have noted, the concerns relating to trade openness are compounded by the social aspects of globalization, such as exposure to foreign cultures, which are important in explaining the change in dietary habits. See Etilé and Oberländer (n 30).

[34] See in particular Nestle (n 29); and Allyn L Taylor and Michael F Jacobson, 'Carbonating the World: the Marketing and Health Impact of Sugar Drinks in Low-And-Middle Income Countries', Center for Science in the Public Interest, Washington DC, 2016.

[35] *State of Food Insecurity in the CARICOM Caribbean - Meeting the 2015 Hunger Targets: Taking Stock of Uneven Progress Subregional Office for the Caribbean*, Food and Agriculture Organization, Bridgetown, Barbados, 2015.

grown much faster than imports of raw foodstuffs, this situation of increasing dependence on energy-dense and nutrient-poor food has led to a dramatic increase in obesity and related NCDs, with half of men and three quarters of women obese or overweight and diabetes double the global average.[36] A similar, even more worrying picture emerges from SIDs in the Pacific region.[37] The concerns relating to the relationship between trade liberalization and childhood obesity were highlighted by the Commission on Ending Childhood Obesity[38] and, more recently, by the Lancet Commission on The Global Syndemic of Obesity, Undernutrition, and Climate Change.[39]

These negative dynamics are compounded by the fact that the food and alcohol industries have managed to portray themselves as key players in the prevention of NCDs at national, regional and global levels. It is well established that they are a major part of the problem of growing rates of NCDs, as we have just discussed. Nevertheless, they have made a range of voluntary pledges and thus purported to be reactive and act faster than States. For example, after the Global Strategy on Diet and Physical Activity was adopted, several food MNCs established the International Food and Beverages Alliance (IFBA) and made several 'pledges' and 'commitments' with a view to convincing public authorities that they could provide cost-effective solutions to the obesity epidemic.[40] As a result, they have succeeded in being perceived by many policy actors around the world as important partners in the prevention of NCDs and therefore a major part of the solution.

The FCTC is clear that the tobacco industry should not be seen as a partner in the prevention of tobacco-related diseases. Article 5.3 of the FCTC requires that

> [i]n setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.

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[36] Andrea Yearwood and T Alafia Samuels, 'Evidence Brief: Improving the Healthiness of Food Environments in the Caribbean', Caribbean Public Health Agency, June 2016. On the evaluation of the Port of Spain Declaration on NCDs, see T Alafia Samuels and Nigel Unwin, 'Accelerating Action on NCDs', PAHO/WHO and CARICOM, September 2016. For a legal analysis, see Nicole Foster, 'International Trade and Childhood Obesity: A Caribbean Perspective', in Garde et al, *Ending Childhood Obesity* (n 21).

[37] Anne Marie Thow et al, 'Trade and Food Policy: Case Studies from Three Pacific Island Countries' (2010) 35 Food Policy 6.

[38] They were discussed in somewhat more detail in WHO, 'Consideration of the Evidence on Childhood Obesity for the Commission on Ending Childhood Obesity: Report of the Ad hoc Working Group on Science and Evidence for Ending Childhood Obesity' WHO 2016) 117.

[39] Boyd Swinburn et al, *The Global Syndemic of Obesity, Undernutrition, and Climate Change: The Lancet Commission Report*, The Lancet, 27 January 2019.

[40] There are 11 IFBA members: The Coca-Cola Company, Ferrero, General Mills, Grupo Bimbo, Kellogg's, McDonald's, Mars, Mondelēz International, Nestlé, PepsiCo and Unilever. In 2016, they employed more than three million people worldwide and had a combined annual revenue of over USD 410 billion: <www.ifballiance.org> accessed 18 January 2020.

This provision takes as its starting point 'what may fairly be described as an expression of profound distrust about the motives of the tobacco industry' and 'assumes a history of deliberate subversion by the industry of governmental health policies'.[41] Recognizing the damage that real, perceived or potential conflicts of interest pose,[42] the international community has explicitly highlighted the 'fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests',[43] and called on States, among others, to 'reject partnerships and non-binding or non-enforceable agreements with the tobacco industry'.[44]

By contrast, neither the Global Strategy on Diet, Health and Physical Activity nor the Global Strategy on the Harmful Use of Alcohol have drawn similar red lines regarding the role of the food and alcohol industries in promoting health. Even the most recent UN Political Declaration calls on States and the international community to:

> [e]ngage with the private sector, taking into account national health priorities and objectives for its meaningful and effective contribution to the implementation of national responses to non-communicable diseases in order to reach Sustainable Development Goal target 3.4 on non-communicable diseases, while giving due regard to managing conflicts of interest.[45]

Unfortunately, however, the specific terms of engagement remain undefined. For example, what would amount to 'giving due regard to managing conflicts of interest'? Clear rules are needed to ensure that real, potential and perceived conflicts of interest are acknowledged and carefully managed.[46] This is all the more fundamental as independent research over the years

[41] *BAT and Others v. Secretary of State for Health*, High Court decision of 19 May 2016: [2016] EWHC 1169 (Admin) para 170. On the interpretation of art 5(3), see also the FCTC Guidelines.

[42] In particular, the WHO Global Action Plan on NCDs recognizes the need to manage real, perceived or potential conflicts of interest as one of its overarching principles, whilst the Framework of Engagement with Non-State Actors (FENSA) states that 'WHO does not engage with the tobacco industry or non-State actors that work to further the interests of the tobacco industry' (para. 44). On 30 May 2017, ECOSOC called on all UN agencies to develop and implement policies to prevent tobacco industry interference: Resolution E/2017/L.21, para 10. As a result, the Board of the United Nations Global Compact (UNGC) strongly supported measures to align the organization's exclusionary criteria with the UN system in the spirit of the FCTC, in case of tobacco: UNGC Board Meeting Report, 19 July 2017. More recently, Resolution 73/2 (n 2) reiterated calls on States to avoid 'any tobacco industry interference' (para 22).

[43] The Guidelines for implementation of Article 5.3 Protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry, adopted by the Conference of the Parties at its third session (decision FCTC/COP3(7)) para 13.

[44] ibid para 17(3).

[45] Resolution 73/2 (n 2) para 43.

[46] It is interesting to note in this respect that some WHO instruments use the language of conflicts of interest avoidance rather than conflicts of interest management. For example, the set of WHO recommendations on the marketing of food and non-alcoholic beverages to children explicitly provide that QUOTE (Recommendation 6). For a fuller discussion, see Amandine Garde et al, 'Implementing the WHO Recommendations whilst Avoiding Real, Perceived or Potential Conflicts of Interest' (2017) 8(2) European Journal of Risk Regulation 237.

has established that voluntary pledges adopted by food and alcohol business actors to address the harm resulting from the consumption of alcohol and unhealthy food have proven ineffective.[47] More work is urgently needed to determine what role the food industry should have and what would amount to conflicts of interest.[48] The assumption cannot be that because food is different from tobacco, partnerships with the food industry in addressing unhealthy diets are appropriate and likely to be effective. Public-private partnerships with the food and alcohol industries have inherent limits. States should adopt laws and regulations that will allow them to provide the level-playing field that MNCs require to operate fairly in a globalized world, whilst meeting their obligation to ensure the enjoyment of the highest attainable standard of health for all.[49]

However, the more robust and effective States regulatory measures are, the more States will have to prepare to meet the vigorous opposition of MNCs that manufacture, distribute and promote tobacco, alcoholic beverages and unhealthy food. In particular, foreign investors can bring compensation claims against host States for any measure that adversely affects investment and may violate an investment treaty obligation. National efforts undertaken by States to regulate the tobacco, alcohol and food industries to prevent NCDs and promote public health could therefore give rise to expensive arbitrations. This risk has already materialized in relation to tobacco, as the recent claims against tobacco control legislation in Australia and Uruguay illustrate.[50] Food and alcohol regulation could face similar high-profile investment challenges. The nexus between private investment and NCD prevention raises important and

[47] For a criticism of the use of self-regulation to limit the marketing of unhealthy food and alcoholic beverages to children and the risk of conflicts of interest in NCD prevention, see in particular: Corinna Hawkes, 'Self-Regulation of Food Advertising: What It Can, Could and Cannot Do To Discourage Unhealthy Eating Habits Among Children' (2005) British Nutrition Foundation, Nutrition Bulletin 374; David Ludwig and Marion Nestle, 'Can the Food Industry Play a Constructive Role in the Obesity Epidemic?' (2008) 15 JAMA 300; Lisa Sharma et al, 'The Food Industry and Self-Regulation: Standards to Promote Success and to Avoid Public Health Failures' (2010) American Journal of Public Health 100:240; Anna B Gilmore, 'Public Health, Corporations and the New Responsibility Deal: Promoting Partnerships with Vectors of Disease?' (2011) 33(1) Journal Of Public Health 2; Moodie et al (n 29); Sarah Galbraith-Emami and T Lobstein, 'The Impact of Initiatives to Limit the Advertising of Food and Beverage Products to Children: A Systematic Review' (2013) Obesity Reviews; Julie Jensen and Karsten Ronit, 'The EU Pledge for Responsible Marketing of Food and Beverages to Children: Implementation in Food Companies' (2015) 69 European Journal of Clinical Nutrition 896; Garde et al (n 46).

[48] Some work is underway. See, in particular: WHO, 'Addressing and Managing Conflicts of Interest in the Planning and Delivery of Nutrition Programmes at Country Level', WHO, Geneva, 2016; and Modi Mwatsama (ed), *Public Health and the Food and Drinks Industry: The Governance and Ethics of Interaction. Lessons from Research, Policy and Practice* (UK Health Forum, 2018).

[49] See in particular the Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover, 'Unhealthy Foods, Non-communicable Diseases and the Right to Health', UN Doc A/HRC/26/31, 1 April 2014, para 25.

[50] *Philip Morris Asia Limited v The Commonwealth of Australia*, UNCITRAL, PCA Case No. 2012-12, Award on Jurisdiction and Admissibility (17 December 2015); *Philip Morris Brands Sàrl, Philip Morris Products S.A. and Abal Hermanos S.A. v. Oriental Republic of Uruguay*, ICSID Case No. ARB/10/7, Award (8 July 2016) (*Philip Morris*).

timely questions about how international investment law can affect State regulatory autonomy in designing and implementing NCD prevention measures. This Special Issue proposes to explore some of these issues.

3 International Investment Law as an Obstacle to the Development of Effective National NCD Prevention Policies?

Since the 1990s, the number of international investment treaties, under which host States are obliged to provide foreign investors with certain legal protections, has increased significantly and now well-surpasses 3,000.[51] In parallel, the number of investor-State disputes, which investors are empowered to initiate against host States by means of arbitration, also surged to almost 1,000 by the middle of 2019.[52] Not uncommonly, investors have brought compensation claims against host States for having passed measures that pursued certain public policy objectives (e.g. environmental and health objectives), but have also interfered with investors' commercial interests.[53] Consequently, international investment treaties and investor-State arbitration have been continuously criticized for encroaching upon a State's right to regulate its public policy interests.[54] At the core of the criticism have been broadly and vaguely worded investment treaty standards, which impose enforceable obligations on host States only and which have often been interpreted by arbitral tribunals to the detriment of their public interests. Furthermore, the ad hoc nature of investor-State arbitration and the absence of an appeal system and a formal system of precedent, renders the investment regime inherently unpredictable.[55] Over the past years, the backlash has culminated in some States withdrawing from the

[51] See United Nations Conference on Trade and Development, 'International Investment Agreements Navigator' (estimating the number of bilateral investment treaties and treaties with investment provisions at 3,285) <https://investmentpolicy.unctad.org/international-investment-agreements> accessed 6 January 2020.
[52] See United Nations Conference on Trade and Development, 'Investment Dispute Settlement Navigator' (31 July 2019) <https://investmentpolicy.unctad.org/investment-dispute-settlement> accessed 1 March 2020.
[53] See e.g. *Metalclad Corporation v The United Mexican States*, ICSID Case No. ARB(AF)/97/1, Award (30 August 2000); *Methanex Corporation v United States of America*, NAFTA-UNCITRAL, Award (3 August 2005).
[54] See e.g. Michael Waibel et al (eds), *Backlash against Investment Arbitration* (Kluwer 2010); Gus Van Harten, *Investment Treaty Arbitration and Public Law* (OUP 2007); David Schneiderman, *Constitutionalizing Economic Globalization: Investment Rules and Democracy's Promise* (CUP 2008); Susan D Frank, 'The Legitimacy Crisis in Investment Treaty Arbitration: Privatizing Public International Law Through Inconsistent Decisions' (2005) 73 Fordham L Rev 1521.
[55] Other systemic problems associated with investor-State arbitration include the lack of requisite expertise of arbitrators, conflict of interests in appointing arbitrators, and lack of procedural transparency. See e.g. Malcolm Langford et al, 'The Revolving Door in International Investment Arbitration' (2017) 20 JIEL 301; Chiara Giorgetti 'Who Decides Who Decides in International Investment Arbitration?' (2013) 35 U Pa J Int'l L 431.

investment law system,[56] while on the other hand, it has also intensified proposals for improving the system through a more balanced drafting and interpretation of investment treaties as well as reforms of the dispute resolution system.[57] Recent arbitration decisions concerning public health, outlined in the next paragraphs, are in many ways indicative of these developments.[58]

That State efforts to reduce risk factors for NCDs and promote public health can give rise to expensive arbitrations, has been illustrated by investors' claims challenging tobacco control legislation in Australia and Uruguay. In 2011, Philip Morris Asia initiated investor-State arbitration against Australia concerning Australia's measures restricting the ability of tobacco companies to differentiate their brands in the design of the packaging. While the case attracted a lot of attention and resulted in Australia incurring significant litigation costs,[59] the Tribunal eventually ruled that it had no jurisdiction to decide the claim.[60] More satisfying for lawyers and public health experts seeking guidance on substantive issues was the case that

[56] See e.g. Bolivia, Ecuador, and Venezuela have denounced the ICSID Convention. See Tania Voon and Andrew D Mitchell, 'Denunciation, Termination and Survival: The Interplay of Treaty Law and International Investment Law' (2016) 31 ICSID Review-Foreign Investment Law Journal 413.

[57] See e.g. UNCITRAL, 'Report of Working Group III (Investor-State Dispute Settlement Reform) on the Work of its Thirty-Eighth Session' (Vienna, 14–18 October 2019) UN Doc No A/CN.9/1004 <https://uncitral.un.org/en/working_groups/3/investor-state> accessed 18 December 2019; Council of the EU, 'Multilateral Investment Court: Council Gives Mandate to the Commission to Open Negotiations' (20 March 2018) <https://www.consilium.europa.eu/en/press/press-releases/2018/03/20/multilateral-investment-court-council-gives-mandate-to-the-commission-to-open-negotiations/> accessed 18 December 2019; ICSID Secretariat Bank, 'Proposal for Amendment of the ICSID Rules – Working Paper #4' (February 2020) < https://icsid.worldbank.org/en/amendments> accessed 1 March 2020.

[58] There is a growing body of academic research focusing on the nexus between international investment law and public health protection, and NCD prevention more specifically. See, in particular: Valentina Vadi, *Public Health in International Investment Law and Arbitration* (Routledge 2013); Benn McGrady, 'Implications of Ongoing Trade and Investment Disputes: Philip Morris v Uruguay' in Tania Voon et al(eds), *Public Health and Plain Packaging of Cigarettes: Legal Issues* (Elgar 2012); T Lin, 'Disputes Regarding Tobacco Control Measures under Investor-State Arbitration' in Andrew Mitchell and Tania Voon (eds), *The Global Tobacco Epidemic and the Law* (Elgar 2014) 126; Andrew Mitchell, 'Tobacco Packaging Measures Affecting Intellectual Property Protection Under International Investment Law: The Claims Against Uruguay and Australia' in Alberto Alemanno and Enrico Bonadio (eds), *The New Intellectual Property of Health* (Elgar 2016); Eva Nanopoulos, Rumiana Yotova, '"Repackaging" Plain Packaging in Europe: Strategic Litigation and Public Interest Consideration' (2016) 19(1) JIEL 175; Mavluda Sattorova, 'Investment Protection Agreements, Regulatory Chill, and National Measures on Childhood Obesity Prevention' in Garde et al, *Ending Childhood Obesity* (n 21); Henning Grosse Ruse-Khan, 'A Conflict-of-Laws Approach to Competing Rationalities in International Law: The Case of Plain Packaging between IP, Trade, Investment and Health' (2013) 9(2) Journal of Private International Law 309; Metka Potočnik, *Arbitrating Brands: International Investment Treaties and Trade Marks* (Elgar 2018).

[59] Reportedly, Australia spent nearly USD 40m defending its world-first plain packaging laws against Philip Morris Asia. See Gareth Hutchens and Christopher Knaus, 'Revealed: $39m cost of defending Australia's tobacco plain packaging laws' (The Guardian, 1 July 2018) <https://www.theguardian.com/business/2018/jul/02/revealed-39m-cost-of-defending-australias-tobacco-plain-packaging-laws> accessed 7 June 2019.

[60] *Philip Morris v Australia* (n 50).

Philip Morris brought against Uruguay, which was decided on the merits in 2016.[61] Since that award expressly addresses the tension between investment protection and NCD prevention, it provides a starting point for this project and is frequently referred to in the contributions of this Special Issue. We provide a brief introduction of the case here.

In 2003, Uruguay was the first Latin American country to sign and ratify the FCTC, which requires its Parties to 'adopt and implement effective legislative, executive, administrative and/or other measures … for preventing and reducing tobacco consumption, nicotine addiction and exposure to tobacco smoke.'[62] Having 'one of Latin America's highest rate of smokers,'[63] Uruguay enacted strong anti-smoking legislation, including the measure requiring that cigarette brands sell only under a single package or variant (so-called 'Single Presentation Requirement' – 'SPR')—not mentioned in the FCTC,[64] and measures requiring that the health warnings on cigarette packages increase from 50% to 80% of the surface of the packages (so-called '80/80 Regulation').[65] Relying on the Switzerland-Uruguay Bilateral Investment Treaty (BIT), Philip Morris challenged the measures on several grounds, including that they resulted in partial expropriation of investment and violated the fair and equitable treatment standard (FET).

The Tribunal, by majority, upheld the legality of the challenged public health measures and dismissed all Philip Morris's claims. It held that there was no case of indirect expropriation by the 80/80 Regulation, as the brand's distinctive elements were still recognizable on cigarette packs,[66] nor was there indirect expropriation by the SPR measures since they did not cause a 'substantial deprivation' of the investment as a whole.[67] The Tribunal stressed that as long the investment as a whole retains sufficient value following the implementation of the contested measures,[68] one cannot speak of indirect expropriation.[69] The Tribunal also rejected the claim

[61] *Philip Morris* (n 50). As a landmark case addressing anti-tobacco regulation, the arbitration garnered a lot of public attention, including personal commitment of the president of Uruguay and financial support from philanthropists like Michael Bloomberg. See e.g., <https://www.bloomberg.org/press/releases/michael-r-bloomberg-commits-360-million-reduce-tobacco-use-raising-total-giving-tobacco-control-efforts-nearly-1-billion/> accessed 15 March 2019.
[62] FCTC, art 5.
[63] *Philip Morris* (n 50) para 75.
[64] ibid para 10.
[65] ibid para 11.
[66] ibid para 276.
[67] ibid para 284. While the Tribunal acknowledged that there is a disagreement in case law as to whether, for the purposes of determining indirect expropriation, the effect of the measure must be considered with reference to investment as a whole or with reference to individual assets comprising investment, it eventually sided with the former approach, arguing that the investor's 'business must be considered as a whole since the measure affected its activities in their entirety.' ibid paras 280, 283.
[68] In the case at hand, the investor's business has, overall, grown more profitable in the period after the implementation of the SPR measures. ibid para 284.
[69] ibid para 286.

for the breach of the FET standard. It found that SPR was not arbitrary and that it presented a reasonable 'attempt to address a real public health concern.'[70] Similarly, it held that the 80/80 Regulations was a 'reasonable measure adopted in good faith', supported by a strong scientific consensus as to the dangers of tobacco.[71]

Overall, the *Philip Morris* award adopted an approach that is favourable to a State's regulatory freedom in public health matters, possibly sending a signal for potential future arbitrations. Three particular aspects of the Tribunal's reasoning are reassuring for States planning to introduce innovative NCD prevention measures. Firstly, the Tribunal ruled that the challenged measures were a valid exercise of Uruguay's police powers, as reflected in customary international law,[72] and hence did not amount to expropriation. It held that the measures were *bona fide*, non-discriminatory and proportionate to the objective pursued.[73] Importantly, the Tribunal stated that 'protecting public health has since long been recognized as an essential manifestation of the State's police power'.[74]

Secondly, in considering the FET claims, the Tribunal took into account Uruguay's status as a developing country,[75] by according wider deference to policy decisions adopted by national authorities in compliance with international standards.[76] Thus, while it acknowledged that the enactment of the challenged measures was not preceded by detailed research, it was sufficient and reasonable that Uruguay as a nation with 'limited technical and economic resources' relied on WHO guidelines in developing such policies.[77] More generally, the majority of the Tribunal held that the 'margin of appreciation' as developed in the case law of the European Court of Human Rights applied also in investment law disputes and that great deference should be paid to 'governmental judgments of national needs'.[78]

Thirdly, the Tribunal limited the scope of investors' legitimate expectations within the FET standard to expectations based on 'specific undertakings' made by the host State.[79] While in the past the question as to whether the changes to general legislation can frustrate investors'

[70] ibid paras 409–10.
[71] ibid para 420,
[72] ibid paras 287, 300.
[73] ibid para 305.
[74] ibid para 291.
[75] ibid para 393.
[76] ibid paras 393–96.
[77] ibid paras 407, 393–94, 396. For more on the Tribunal's engagement with the WHO rules, see Margherita Melillo, 'Evidentiary Issues in Philip Morris v Uruguay: The Role of the Framework Convention for Tobacco Control, and Lessons for NCD Prevention' (in this Special Issue).
[78] *Philip Morris* (n 50) para 399.
[79] ibid para 426.

legitimate expectations gave rise to inconsistent jurisprudence,[80] the *Philip Morris* award has clarified that cigarette manufacturers and distributors cannot expect to avoid 'new and more onerous regulations',[81] and should in fact only expect 'progressively more stringent regulation' in view of the widely accepted 'international concern for the harmful effect of tobacco'.[82]

While many have celebrated the *Philip Morris* award as an acknowledgment of investment law's ability to respect State's autonomy in regulating public health,[83] and as a disincentive for future claims from tobacco companies in developing countries,[84] others have been more cautious, pointing to the substantial financial and personal resources Uruguay spent on litigating the case,[85] and the regulatory chill the arbitration has caused in other Latin American countries, including Costa Rica and Paraguay.[86] With respect to the latter, commentators have pointed out that the risk of arbitration claims with potential liabilities in damages and/or legal costs may curtail options for public action that governments wish to pursue, thereby 'shrinking democratic space'.[87] For example, it was reported that the Philip Morris legal action against Australia caused the New Zealand Government to delay enactment of anti-tobacco legislation until the investment claims were finally dismissed (altogether for

[80] For an overview, see Michele Potesta, 'Legitimate Expectations in Investment Treaty Law: Understanding the Roots and the Limits of a Controversial Concept' (2013) 28(1) ICSID Review 88.
[81] *Philip Morris* (n 50) para 429
[82] ibid para 430.
[83] Harold Koh, 'Global Tobacco Control as a Health and Human Rights Imperative' (2016) Harv. Int'l L.J. 433, 447; Tania Voon and Andrew Mitchell, 'Philip Morris v Tobacco Control: Two Wins for Public Health, but Uncertainty Remains' (2016) 182 Columbia FDI Perspectives, <http://ccsi.columbia.edu/files/2013/10/No-182-Voon-and-Mitchell-FINAL.pdf> accessed 5 March 2019; Tania Voon, 'Philip Morris v Uruguay: Implications for Public Health' (2017) 18 JWIT 320; Recent International Decision, 'Philip Morris Brands Sàrl v. Oriental Republic of Uruguay' (2017) 130 Harvard Law Review 1986; Kate Mitchell, "Philip Morris v Uruguay: An Affirmation of 'Police Powers' and 'Regulatory Power in the Public Interest'" (2016) European Journal of International Law, online: EJIL: Talk <https://www.ejiltalk.org/philip-morris-v-uruguay-an-affirmation-of-police- powers-and-regulatory-power-in-the-public-interest-in-international-investment-law/> accessed 5 March 2019; Caroline E Foster, 'Respecting Regulatory Measures: Arbitral Method and Reasoning in the Philip Morris v Uruguay Tobacco Plain Packaging Case' (2017) 26(3) RECIEL 287; Praytush N Upreti, 'Philip Morris v Uruguay: A Breathing Space for Domestic IP Regulation' (2018) 40(4) European Intellectual Property Review 277.
[84] Koh (n 83).
[85] Cecilia Olivet and Alberto Villareal, 'Who Really Won the Legal Battle between Philip Morris and Uruguay' (28 July 2016) <https://www.tni.org/en/article/who-really-won-the-legal-battle-between-philip-morris-and-uruguay> accessed 7 June 2019 (noting how Uruguay had to pay '$2.6 million in financial costs and much more in non-material resources').
[86] ibid.
[87] See e.g., Lorenzo Cotula, 'Democracy and International Investment Law' (2017) 30(2) Leiden Journal of International Law 351, 362; David Schneiderman, 'Investing in Democracy? Political Process and International Investment Law' (2010) 60(4) University of Toronto Law Journal 909, 910; Stephan Schill, 'Do Investment Treaties Chill Unilateral State Regulation or Mitigate Climate Change?' (2009) 24(5) Journal of International Arbitration 496; Kyla Tienhaara, 'Regulatory Chill and the Threat of Arbitration: A View from Political Science' in Chester Brown and Kate Miles (eds), *Evolution in Investment Treaty Law and Arbitration* (CUP 2011) 606.

more than three years).[88] Developing countries, which are the most affected by NCDs, are particularly susceptible to be affected by the regulatory chill, as they are more likely to become apprehensive about pursuing their regulatory objectives due to their limited resources necessary for effective engagement with investor-State arbitration.[89] The overall pro-public health outcome of the Uruguay award, does not really alleviate these concerns. The fragmented nature of investor-State arbitration system and the fact that the award is not a binding precedent undermine the significance and effects of such single cases for future similar disputes.

Moreover, the fact that one of the arbitrators partially dissented, holding that Uruguay's SPR measures were 'arbitrary and unreasonable', since, among others, they were not preceded by any consultation with tobacco industry representatives (an obligation which may run counter Article 5.3 of the FCTC, as discussed above),[90] is indicative of persisting uncertainties as to how future tribunals will deal with cases concerning public health objectives and tobacco control more specifically.[91] It is entirely possible that food and alcohol MNCs follow the *Philip Morris* example in attempting to halt the adoption of innovative measures by developing countries mindful to promote better health on their territories.[92] To what extent the lessons from *Philip Morris* can be extrapolated to alcohol and unhealthy food is one of the questions that this Special Issue seeks to address.

4 Structure of the Special Issue

Five articles follow this introduction. The first three explore the effects that international investment treaties have on a host States' process of regulating NCD risk factors to reduce the

[88] 'Government Moves Forward with Plain Packaging of Tobacco Products' <https://www.beehive.govt.nz/release/government-moves-forward-plain-packaging-tobacco-products> accessed 15 March 2019 (reporting that the New Zealand Government acknowledged that the outcome of *Philip Morris* arbitration would affect the enactment of anti-tobacco legislation in New Zealand). For more on regulatory chill and tobacco industry, see also Oleksandra Vytiaganets, 'Smoking Chills? Tobacco Regulatory Chill, Foreign Investment, and the NCD Crisis in the Post-Soviet Space: a Case Study from Ukraine' (in this Special Issue).

[89] Tienhaara (n 87) 611–12 (noting how developing countries often cannot afford law firms specialising in investor-State arbitration and must instead rely on state attorneys with less experience and limited access to necessary resources).

[90] *Philip Morris* (n 50) Concurring and Dissenting Opinion, para 82. See also Caroline Henckels, 'A Duty to Consult Foreign Investors When Changing the Regulatory Framework? Implications for Non-Communicable Disease Prevention and Beyond' (in this Special Issue).

[91] Voon and Mitchell (n 83); Voon (n 83); Prabhash Ranjan, 'Police Powers, Indirect Expropriation in International Investment Law, and Article 31(3)(c) of the VCLT: A Critique of Philip Morris v. Uruguay' (2019) 9 Asian Journal of International Law 98, 102.

[92] See Andrew Mitchel and Paula O'Brien, 'If One Thai Bottle Should Accidentally Fall: Health Information, Alcohol Labelling and International Investment Law', and Marcelo Campbell, 'NCD Prevention and International Investment Law in Latin America: Chile's Experience in Regulating Obesity and Unhealthy Diets' (both in this Special Issue).

harmful consumption of tobacco, alcohol and unhealthy diets. The final two provide regional case studies, reflecting on the nexus between international investment law and national NCD prevention policies in Eastern Europe (specifically in Ukraine) and in Latin America (specifically in Chile).

First, Andrew Mitchell and Paula O'Brien examine legal issues that may emerge in international investment law as a result of alcohol labelling measures, using Thailand as a case study. Thailand has been a trailblazer in developing measures for addressing alcohol-related harm, thus signalling a shift in public health policy more broadly. Over the past years, it has proposed two types of innovative public health measures concerning labelling of alcoholic beverages, which have given rise to contentious debates in the context of international trade law and could possibly be subjected to investment arbitration claims in the future. The first measure requires that alcohol labels contain graphic warnings including photo-style images, displayed on a large area of the product, in the same manner as tobacco-style warnings. The second measure prohibits a number of popular alcohol marketing techniques including restrictions on the words and images (e.g. cartoons) that can be used on alcoholic beverage labels. Mitchell and O'Brien explore whether these measures are consistent with investment treaty obligations that are most likely to be invoked by alcohol producers, namely the FET standard and indirect expropriation. The article analyses different aspects of the labelling measures that investment tribunals would have to consider, thereby identifying the weaknesses in drafting of these measures, and offering guidance on how they could be shaped for greater alignment with investment treaty obligations.

Secondly, Caroline Henckels focuses on a particular aspect of the FET standard, namely whether this investment treaty provision obliges governments to consult foreign investors in the process of adopting and implementing new laws and policies that may adversely affect them. The question is of significant importance for the regulation of NCD risk factors, the area in which industry actors tend to exert great influence with an aim of thwarting government efforts in developing public health policies that are detrimental to investors' business interests. As noted by Henckels, the tobacco industry has been particularly vocal in challenging tobacco control measures on the ground that the relevant industry actors were not consulted or that consultation was insufficient. She examines how investment tribunals, within the context of applying differently worded FET clauses, have discussed a duty of consultation in State's law-making process. While some arbitral decisions may be read as confirming the existence of an obligation to consult in the law-making process, Henckels concludes that at most investor consultation was treated as one of many elements in substantive review of the measure in

question, rather than a standalone procedural duty incorporated in FET or customary international law. She further surveys the practice of mandatory consultation in various domestic legal systems and argues that there is no general principle of law imposing such an obligation. The article concludes by examining the compatibility of the obligation to consult, as included in some domestic laws or investment treaties, with Article 5(3) of the FCTC, which requires State parties to protect their tobacco control policies from industry interference.

Thirdly, Margherita Melillo's article analyses the evidentiary assessment made by the investment tribunal in the *Philip Morris* case, and more specifically the use of the FCTC as evidence for the purpose of international litigation. While the Tribunal extensively relied on the FCTC in rejecting the investor's claim, this contribution raises important questions about what it means to use an evidence-based treaty in litigation,[93] highlighting potential benefits and limitations. The article discusses various evidentiary challenges that international courts and tribunals face when adjudicating disputes over NCD prevention laws and policies. Melillo shows how the *Philip Morris* tribunal avoided engaging in a comprehensive assessment of the scientific evidence submitted by the parties and instead largely relied on the FCTC and the WHO's and the Pan-American Health Organization's interpretations. Drawing on the lessons learnt from that case, she makes several general observations on the use of evidence-based international instruments. While she stresses the need to further develop existing international evidence-based instruments relevant to NCD prevention, and the importance that low- and medium-income countries participate in their development, she also points to the weakness of such instruments and proposes drafting solutions.

The last two contributions of this Special Issue reflect on recent policy developments at regional level. In her article, Oleksandra Vytiaganets draws attention to Eastern Europe, more specifically Ukraine, a country which is popular with foreign investors but also experiences a severe NCD crisis. In the aftermath of the collapse of the Soviet Union, Ukraine has strongly prioritized the objective of attracting FDI to promote economic growth, not least by providing extensive guarantees to international investors in the form of investment agreements. At the same time, the country's response to the growing NCD crisis has been slow and inadequate. The article argues that the two developments are related, and that the activities of foreign investors have led to deregulation and a lowering of public health standards in the country. Drawing on her empirical findings, Vytiaganets shows that Ukrainian public officials,

[93] An evidence-based treaty is a treaty that is grounded in science and in the evidence-based practices and experience of its parties.

whose work is related to international investment, lack awareness of the potential consequences of investment treaty obligations for State regulatory freedom, and moreover, that some have been influenced by the lobbying of industry actors. As a result, the parliamentary discussions of the proposed measures for controlling NCD-related risks have been hampered or continuously delayed.

Finally, Marcelo Campbell presents the experience of Latin American countries, and Chile more specifically. In 2016, Chile became the first country in Latin America to implement comprehensive regulations intended to address obesity and related NCDs. It introduced innovative measures, including a mandatory front-of-pack nutrition labelling scheme for food products high in sodium, free sugars, fats and calories, as well as strict restrictions on the advertising and marketing of these products to children under 14 years of age. However, the lawfulness of these measures has been called into question in the context of the World Trade Organization's Technical Barriers to Trade Committee, and food companies have filed several complaints before Chilean courts challenging their implementation. Campbell's article provides an overview of some of the legal issues raised in these lawsuits and examines Chile's measures under the rules of international investment law. Drawing parallels with the tribunal's reasoning in the *Philip Morris v. Uruguay* award, Campbell argues the Chilean measures are not arbitrary but are instead reasonable and proportionate and that they should therefore be able to withstand a treaty claim based on indirect expropriation, and breach of the national treatment standard and FET standard.

5 The Need to Build Legal Capacity as Part of Effective NCD Prevention Strategies

Read together, the contributions in this Special Issue confirm that States have significant regulatory space to ensure a high level of public health protection in the development and implementation of their national policies and thus fulfil their obligations to uphold the right to health and related rights on their territories. Provided that the key principles of international investment law are complied with, not least the principles of non-discrimination, necessity, due process and legitimate expectations, States should not fear to regulate the tobacco, alcohol and food industries in line with the developing consensus that these industries, and particularly MNCs operating globally, have been major contributors to growing rates of NCDs throughout the world.

With an increased focus on 'NCD promoting' environments in which consumption choices are influenced by major economic actors, it is logical that the question of the role of law is gaining increasing importance in the NCD prevention debate at both national and international levels. Not only do the international commitments of States to reduce NCD prevalence often call for a robust regulatory intervention, but there is a growing recognition that law as a discipline has a major role to play in the framing of effective NCD prevention strategies at global, regional and national levels. In October 2017, States gathered in Montevideo to prepare the Third UN High Level Meeting on NCDs of September 2018 and 'restate [their] commitment to take bold action and accelerate progress to, by 2030, reduce by one-third the premature mortality from [NCDs] in line with the 2030 Agenda for Sustainable Development'. For the first time, they explicitly acknowledged the need for legal expertise in this field:

> We will enhance policy and legal expertise to develop NCDs responses in order to achieve the SDGs. We call upon the UN Inter-Agency Task Force on the Prevention and Control of NCDs and its Members, within their mandates, to scale up and broaden intersectoral work integrating expertise relevant to public health-related legal issues into NCD country support, including by providing evidence, technical advice, and case studies relevant to legal challenges. We encourage the UN Inter Agency Task Force on the Prevention and Control of NCDs to explore the relationship between NCDs and the law to improve support to Member States in this area and to raise the priority it gives to this work.[94]

This Special Issue, which discusses the nexus between international investment law and NCD prevention and which focuses on the three main NCD risk factors rather than on tobacco alone, will hopefully contribute—modestly—to these legal capacity building efforts by reflecting on the lessons that can be learned from tobacco control for the regulation of the food and alcohol industries.

[94] WHO Montevideo Road Map 2018-2030 on NCDs as a Sustainable Development Priority, 18–20 October 2017, para 21.