⑨ Dr. Martha Spiess

Alcohol, tobacco, public health ... and trade treaties

Let's not let trade treaties block health-promoting policies in Maine

Submission to Maine Citizen Trade Policy Commission, Lewiston, Maine May 11, 2006

By Dr. Martha Spiess

Thank you Senator Rotundo, Representative Patrick and the members of the Maine Citizen Trade Policy Commission for holding this hearing.

As one who has been trained as a veterinarian, I am keenly interested in many aspects of public health policy. I have recently been interested in learning how trade treaties can undermine governments' ability to control tobacco and alcohol—two products that cause substantial harm to public health.

Trade treaties have traditionally been viewed as a way of increasing economic efficiency... Of reducing commodity prices, increasing competition and stimulating more vigorous marketing. According to standard economic theory, trade treaties are supposed to lead to increased production and consumption of commodities, or goods.

These treaties are designed to make goods *cheaper* as taxes are lowered,
more accessible as market restrictions are eliminated,
and *more desirable* to consumers as they are advertised and otherwise promoted.

(See: Grieshaber-Otto, J., Jernigan, D. (2001) Trade treaties, alcohol and public health, *The Globe*, New Series Issue 2, 6-9, http://www.ias.org.uk/publications/theglobe/01issue2/globe0102_p6.html).

But these treaties don't just deal with "goods"; they also cover "bads".
That is, commodities that, when consumed, lead to public health problems.

I'm speaking here specifically of tobacco and alcohol.

Most people are aware that tobacco kills.
Tobacco is the only product that kills when consumed exactly as recommended.

Why should the sales and consumption of tobacco be boosted by international trade treaties?

- Why should tobacco be made cheaper as tobacco taxes are lowered ... when it should be made more expensive?
- Why should tobacco be made more easily accessible to citizens through the elimination of market restrictions... when it should be made less accessible --especially to young people?
- Why should tobacco be made more desirable to youth through global advertising ... when we should be *reducing* tobacco advertising, sponsorships and other promotions to protect young people worldwide?

There is a strong argument, which has been advanced even by a key former negotiator with the United States Trade Representative, that tobacco should be viewed as an exception to trade treaty rules.

(See Shapiro, Ira, Treating Cigarettes as an Exception to the Trade Rules, in SAIS Review, vol. XXII no. 1 (Winter-Spring 2002), pp. 87-96. (Ambassador Shapiro served in the office of the USTR from 1993-1997, first as General Counsel and then as Chief Negotiator with Japan and Canada).

The same argument can and should be applied to alcohol.

From a public policy perspective, alcohol is "flying under the radar" of public perception.
It's where tobacco was 10-15 years ago.

Most people are surprised to learn that globally, alcohol causes nearly as much death and disability as tobacco. According to the World Health Organization, alcohol consumption is the leading risk factor for disease burden in low-mortality developing countries, and the third largest risk factor in developed countries.
There are causal relationships between alcohol consumption and more than 60 types of disease and injury including traffic fatalities.

(See: Babor, T. et al. (2003) No Ordinary Commodity: Alcohol and Public Policy, Oxford: Oxford University Press.)

Tobacco *used* to be considered fashionable.
Alcohol still is.

In both cases, huge companies continue to spend billions of advertising dollars targeting young people, trying to get them to start smoking and drinking.

And, regrettably, trade treaties apply both to tobacco and alcohol.
These treaties place ever greater restrictions on government actions, making it more difficult for governments around the world to regulate tobacco and alcohol to improve public health.

Shockingly, our federal government is currently pressuring other countries in a way that could make things much worse. The US is requesting other countries make concessions in the current round of the WTO services negotiations—in the form of collective GATS requests in Distributions Services. Together with the European Communities and others, the U.S. is co-sponsoring a collective request of 19 countries to make full National Treatment commitments "with no limitations" in Distribution Services, which is understood to include alcohol. If this demand is accepted, it would make it more difficult for these other countries to regulate tobacco and alcohol in the public interest.

But there have been positive developments which we can build upon here in Maine.

In 2005, the Framework Convention on Tobacco Control came into force. This is the first legally binding treaty sponsored by the World *Health* Organization (in contrast with trade treaties sponsored by the World *Trade* Organization). It is designed to reduce tobacco-related deaths and disease world-wide by restricting the supply and demand for the product. It provides a model for a similar initiative that is now being proposed for alcohol. Such a health-promoting treaty could insulate alcohol policy from trade treaty rules. It could enable governments to pursue the most effective public policies unhindered by trade treaty rules. Here in Maine, we should actively promote—and insist that our governments actively support and promote -- the adoption of a Framework Convention on Alcohol Control.

There is a growing recognition in Maine that we need to implement health-promoting policies for tobacco and alcohol.

As a first step, Maine must safeguard its "policy space". It needs to ensure that current and future *trade* treaties do not constrain our ability to control tobacco and alcohol in the public interest.

We should insist that alcohol and tobacco not be treated as ordinary commodities under trade treaties. On this, we can follow the recommendation of the World Medical Association, the global representative body for physicians. At its October 2005 annual assembly, physicians representing more than 40 countries emphasized the need to reduce the global impact of alcohol on health and society in part by shielding alcohol policy from trade treaty constraints. The WMA recommends that:

> "[I]n order to protect current and future alcohol control measures, [National Medical Associations should] advocate for consideration of alcohol as an extra-ordinary commodity and that ***measures affecting the supply, distribution, sale, advertising, promotion or investment in alcoholic beverages be excluded from international trade agreements***."
>
> (World Medical Association (2005) Statement on Reducing the Global Impact of Alcohol on Health and Society, SMAC/Alcohol/Oct2005/2, adopted at 171st WMA Council Session, WMA General Assembly, Santiago, Chile, October 17, italics added for emphasis.)

(A copy of the WMA statement is appended to this presentation.)

Maine should act on the World Medical Association proposal by requesting that tobacco and alcohol be exempted from all future bilateral, regional and global trade treaties.

Specifically, with respect to the current round of WTO services negotiations that are now underway in Geneva…

Maine should request that the United States Trade Representative:

- **Not make any GATS *offers* affecting** the supply, distribution, sale, advertising, promotion or investment of **tobacco and alcoholic beverages** in Maine; and
- **Refrain from making any GATS *requests* of other countries pertaining to these service sectors.**

In particular, Maine should request that the federal government instruct the new United States Trade Representative to **withdraw U.S. support for the collective (or "plurilateral") request it has co-sponsored on Distribution Services as it pertains to alcohol and tobacco.**

Thank you very much for your attention.

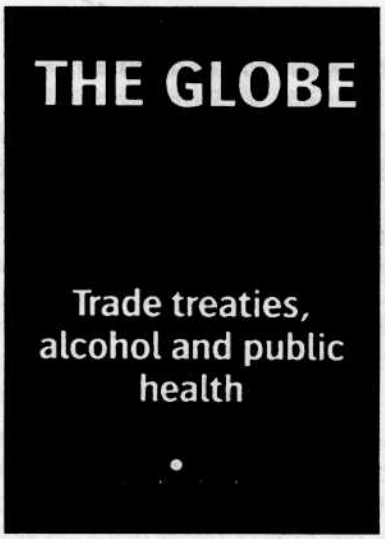
I look forward to learning of your further deliberations and of the Commission's efforts

- to restrict the application of harmful trade treaty rules in Maine, and
- to pursue alternative treaty models that have the potential to improve, rather than threaten, public health in relation to tobacco and alcohol consumption.

THE GLOBE

Global Alcohol Policy A...

The Globe - Issue No 2 2001



On the cover of this issue:

- Trade treaties, alcohol and public health

Also in this issue:

This issue of The Globe is now available in pdf format. Click on the link to download.
The Globe - Issue 2 2001 - pdf (432kb)
The Globe (links to previous issues)

Global Alcohol Policy Alliance|Alliance House
12 Caxton Street| London | SW1H 0QS| Tel: 0207 222 4001| Contact Gapa
Copyright 2003

Home

Recommendations

The WMA urges National Medical Associations and all physicians to take the following actions to help reduce the impact of alcohol on health and society:

11. Advocate for comprehensive national policies that
    a. incorporate measures to educate the public about the dangers of hazardous and unhealthy use of alcohol (from risky amounts through dependence), including, but not limited to, education programs targeted specifically at youth;
    b. create legal interventions that focus primarily on treating or provide evidence-based legal sanctions that deter those who place themselves or others at risk, and
    c. put in place regulatory and other environmental supports that promote the health of the population as a whole.
12. Promote national and sub-national policies that follow 'best practices' from the developed countries that with appropriate modification may also be effective in developing nations. These may include setting of a minimum legal purchase age, restricted sales policies, restricting hours or days of sale and the number of sales outlets, increasing alcohol taxes, and implementing effective countermeasures for alcohol impaired driving (such as lowered blood alcohol concentration limits for driving, active enforcement of traffic safety measures, random breath testing, and legal and medical interventions for repeat intoxicated drivers).
13. Be aware of and counter non-evidence-based alcohol control strategies promoted by the alcohol industry or their social aspect organizations.
14. Restrict the promotion, advertising and provision of alcohol to youth so that youth can grow up with fewer social pressures to consume alcohol. Support the creation of an independent monitoring capability that assures that alcohol advertising conforms to the content and exposure guidelines described in alcohol industry self-regulation codes.
15. Work collaboratively with national and local medical societies, specialty medical organizations, concerned social, religious and economic groups (including governmental, scientific, professional, nongovernmental and voluntary bodies, the private sector, and civil society) to:
    a. reduce harmful use of alcohol, especially among young people and pregnant women, in the workplace, and when driving;
    b. increase the likelihood that everyone will be free of pressures to consume alcohol and free from the harmful and unhealthy effects of drinking by others; and
    c. promote evidence-based prevention strategies in schools.
16. Undertake to
    a. screen patients for alcohol use disorders and at-risk drinking, or arrange to have screening conducted systematically by qualified personnel using evidence-based screening tools that can be used in clinical practice;
    b. promote self-screening/mass screening with questionnaires that could then select those needing to be seen by a provider for assessment;
    c. provide brief interventions to motivate high-risk drinkers to moderate their consumption; and
    d. provide specialized treatment, including use of evidence-based pharmaceuticals, and rehabilitation for alcohol-dependent individuals and assistance to their families.
17. Encourage physicians to facilitate epidemiologic and health service data collection on the impact of alcohol.
18. Promote consideration of a Framework Convention on Alcohol Control similar to that of the WHO Framework Convention on Tobacco Control that took effect on February 27, 2005.
19. Furthermore, in order to protect current and future alcohol control measures, advocate for consideration of alcohol as an extra-ordinary commodity and that measures affecting the supply, distribution, sale, advertising, promotion or investment in alcoholic beverages be excluded from international trade agreements.

http://www.wma.net/e/policy/a22.htm

Drug Company Uses U.S. Trade Agreement to Challenge Australian Health Program
California Legislators Concerned State Drug Programs Are Next

Sacramento – Concerns expressed just over a year ago by State Senator Liz Figueroa (D-Fremont) are now ringing true as an international trade agreement is being used to undermine government efforts to keep prescription drugs affordable. The pharmaceutical company Eli Lilly is using the U.S. – Australia Free Trade Agreement to challenge an Australian drug purchasing decision.

"The challenge to Australia's health program is a clear sign of the legal maneuvering by pharmaceutical companies to undercut government strategies that provide affordable drugs for residents," said Figueroa. "We have no assurances that California's affordable drug programs are immune to similar back-door attacks."

The challenge comes after the Australian government refused to put an osteoporosis drug on their drug formulary under the Pharmaceutical Benefits Scheme (PBS), noting that the drug had "uncertain clinical benefit" and "uncertain and unacceptable cost-effectiveness."

The Australian PBS weighs a variety of factors, including cost, to determine whether new drugs will be covered by the government program. California and many other states use contract lists or preferred drug lists (PDL) as a way to promote efficacious, safe and cost-effective products and to discourage the promotion of excessively expensive alternatives. The main difference between state PDL's and the Australian PBS is that Australia outright eliminates coverage for any drug not placed on the formulary, whereas states cover the drug but require prior authorization of any drug not placed on a preferred drug list. In both cases, the threat of not being placed on the preferred list encourages drug companies to lower their prices.

A little known provision in the Australia trade agreement reduces government bargaining power by essentially making it a trade violation for governments to consider cost in prescription drug programs. It further allows private companies to seek independent reviews of government drug coverage decisions, a provision that Eli Lilly is using to challenge the Australian decision.

Senator Figueroa and other legislators are seeking a legally binding commitment from the U.S. government that the U.S. - Australia Free Trade Agreement can not be used to undermine state drug programs.

SJR 25, authored by Figueroa, calls on the federal government to issue an "Interpretive Note" with the government of Australia clarifying that state health programs and other programs that receive federal funding are not covered by the scope of the agreement. The resolution was approved by the Senate earlier today and now heads to the Assembly for further review.

For More Information: Laura Metune, 916.651.1694, Laura.metune@sen.ca.gov

Martha Spuss

5/11/2006