



Public Health Association
AUSTRALIA

Public Health Association of Australia submission on the inquiry into the PACER Plus Agreement

Contact for recipient:
Committee Secretary
Joint Standing Committee on Treaties
Parliament of Australia
A: PO Box 6021, Parliament House,
Canberra ACT 2600
E: jsct@aph.gov.au T: (02) 6277 4002

Contact for PHAA:
Michael Moore – Chief Executive Officer
A: 20 Napier Close, Deakin ACT 2600
E: phaa@phaa.net.au T: (02) 6285 2373

15 February 2018

Contents

Introduction.....	3
The Public Health Association of Australia	3
Vision for a healthy population	3
Mission for the Public Health Association of Australia	3
Preamble	4
PHAA position on PACER Plus	5
Background to the PACER Plus agreement	5
Overview of the impacts of the agreement	5
Specific implications of the PACER Plus agreement on health outcomes.....	5
Conclusion and recommendations.....	8
References.....	9

Introduction

The Public Health Association of Australia (PHAA) welcomes the opportunity to provide input to the Joint Standing Committee on Treaties (“JSCT”) inquiry into the PACER Plus Agreement.

The Public Health Association of Australia

The PHAA is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public’s health in Australia. The PHAA works to ensure that the public’s health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people’s health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

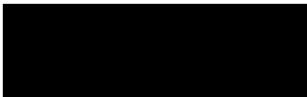
All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health. The reduction of social and health inequities should be an overarching goal of national policy and recognised as a key measure of progress. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.



Preamble

The PHAA believes that a fair regime of regulating trade, investment and intellectual property should prioritise health and social and ecological sustainability just as much as it prioritises economic development.

Australia's International trade agreements should not limit or override the ability of elected parliaments – including state/territory, nation and those of other nations – to legislate and regulate for the health and well-being of their citizens.

Trade and investment agreements, and their dispute settlement mechanisms, should be consistent with international law and also with World Health Organisation (WHO) decisions with regard to health, human rights, the environment, and worker protection.

Trade and investment agreements should:

- a. Prioritise equity within and between countries for global population health improvement.
- b. Not limit or override a country's ability to foster and maintain systems and infrastructure that contribute to the health and well-being of its citizens, nor penalise a government for doing so
- c. Preserve policy space for governments to regulate to protect public health
- d. Be negotiated in a transparent fashion, with opportunities for public and parliamentary scrutiny before commitments are made
- e. Be subject to health and environmental impact assessments, carried out by parties independent of corporate interests.

PHAA supports the implementation of WHO Resolution 59.26, which mandates WHO to provide advice to governments regarding the implications of trade agreements for health.¹ The PHAA is concerned that while negotiations are carried out in secret this has not been done – or alternatively that advice has been ignored.

The PHAA is concerned for the need for an absolute exclusion on a government's ability to control tobacco as set out by WHO in the Framework Convention on Tobacco Control².

Too many trade agreements are currently negotiated in secret. Public health professionals and the public rely on leaked drafts for information about the issues under negotiation.³ ***The PHAA calls for transparent trade negotiating practices and for the routine use of independent health, environmental and human rights impact assessment during negotiations, before agreements are finalised and after implementation.***

Alternative financing mechanisms that do not rely on intellectual property (IP) protection and monopoly pricing should be supported to facilitate access to essential medicines and the development of

██████████ diseases of the developing world.⁴

██████████ should not further entrench and expand a global IP regime that fails to deliver affordable access to medicines for much of the world's population.

PHAA position on PACER Plus

Background to the PACER Plus agreement

PACER Plus, an initiative under the framework of the Pacific Agreement on Closer Economic Relations (PACER) international agreement of 2002, is a multilateral trade liberalisation agreement being negotiated between Australia, New Zealand and a number of Pacific island nations.

Under the PACER framework, Pacific region governments negotiated for the more detailed PACER Plus trade agreement from 2009 to 2017. A final text was agreed by negotiators in June 2017. Eleven of the fourteen governments concerned have signed the final draft of the negotiated agreement.

Legislation to implement the PACER Plus agreement in Australia has now been presented to the Australian Parliament, and it is this legislation which is before the JSCT for inquiry.

PACER is an unusual international trade negotiation group in that two of the negotiating parties – Australia and New Zealand – are dramatically larger economies and more empowered negotiating parties than the remainder of the state parties.

It must also be noted that two Pacific Island Countries – Papua New Guinea and Fiji – who between them form a very large population and GDP share of the Pacific island nations, have declined to sign the present agreement. Apart from Australia and New Zealand, the remaining signatories are all among the smallest and least empowered nations in the world.

Overview of the impacts of the agreement

The agreement would extensively liberalise flows of goods, services and investments between the member nations of the agreement.

However, the agreement is significantly premised on tariff reductions by Pacific island countries, in circumstances where tariffs and barriers between the island nations and Australia and New Zealand are already minimal. Given the realities of Pacific island economies, this liberalisation will therefore in fact largely operate to the benefit of Australian and New Zealand businesses and investors.

The PHAA's prime concern about the impacts of trade liberalisation regimes such as PACER Plus on the ongoing legislative and government capacity of Pacific island countries to adopt sound public health policies.

Specific implications of the PACER Plus agreement on health outcomes

Increased exposure to health damaging products

[REDACTED] potential to damage the health of Pacific islanders by increasing exposure to health-damaging products such as ultra-processed food, alcohol and tobacco.

There is a substantial body of evidence indicating that reduction of tariffs and other 'barriers to trade' in food products can lead to increased availability and lower prices of unhealthy foods, and can affect household food security (Labonte et al, 2011).⁵ The PACER Plus tariff schedules indicate that some Pacific island countries have made commitments to reduce or eliminate tariffs on tobacco products, alcoholic beverages and a variety of processed foods.

It is important that the Committee examine the issue of tobacco. For Australia to support in any way the reduction of tariffs on tobacco is simply unconscionable. Tobacco is the only product in the world when

PHAA submission on the inquiry into the PACER Plus Agreement

used as directed prematurely kills two thirds of its users ten years earlier than they would otherwise have died⁶. Although the Pacer Plus agreement provides some protection for governments to act to protect health and environments, it is worth assessing whether any of these measures would be challengeable as to whether they are health, social or environmental measures opening the way for “regulatory chill”⁷ that could effectively restrict small low to middle income countries from protecting their populations. There ought to be a clear exemption on tobacco in Pacer Plus.

Risks associated with liberalisation of health services

Liberalisation of health services can lead to the proliferation of higher cost, private services which can only be accessed by wealthier sections of the population. This can ultimately lead to a two-tier health system and erode access and equity.

Trade in services commitments do not force countries to privatise their health services, but when governments do privatise services binding commitment in trade agreements can make it difficult to unwind privatisation and reconfigure health systems according to population need and government priorities (Smith et al, 2009).⁸

Trade in health services can also:

- Place limits on governments’ ability to regulate health services and support local service development
- Promote medical tourism, diverting needed human and other resources from the public health sector
- Facilitate foreign investment in health systems, eroding equity and increasing out-of-pocket payments (Missoni, 2013).⁹

Many of the Pacific island countries have made commitments in PACER Plus to liberalise some health services, such as medical and dental services, and some professional services, such as those provided by midwives, nurses, physiotherapists and paramedics. Some countries (e.g. Vanuatu and Tonga) have made commitments for health-related services that go beyond their existing commitments under the World Trade Organization (WTO). The Cook Islands, Federated States of Micronesia, Niue and Marshall Islands, none of which are WTO members, have all made extensive commitments to liberalise health-related services in PACER Plus.

Government capacity to raise revenue and provide health services

PHAA is also concerned about the potential impacts on the revenue base of the Pacific island countries, damage which may constrain the capability of these nations to provide health services to their people. Some of the Pacific island countries are highly dependent on tariffs as a source of revenue.

[REDACTED] Associates Inc. found that Fiji, Papua New Guinea, Samoa and Vanuatu could lose [REDACTED] in revenue each year and the total revenue for the Cook Islands, Kiribati, Samoa, Tonga and Vanuatu could be reduced by more than 10%.

While it may be possible to replace revenue generated from tariffs with excise or value added taxes, these taxes are more resource intensive to collect and difficult to enforce in developing countries.

Historically, developing countries have been slow to recover from revenue losses arising from trade liberalisation, even when value added taxes are introduced to offset these (Baaunsgaard & Keen, 2005).¹⁰ Furthermore, tariffs can be targeted to discretionary items purchased mainly by those on higher incomes,

PHAA submission on the inquiry into the PACER Plus Agreement

whereas value added taxes are generally distributed across the whole population, creating equity concerns for low income groups.

Burdensome requirements to justify health measures

PACER Plus includes a chapter on Technical Regulations, Standards and Conformity Assessment Procedures which aims to ensure that such regulations, standards and procedures do not present unnecessary barriers to trade.

This includes obligations to justify regulations or standards that are perceived by other parties as more trade restrictive than necessary or that are not based on existing international standards. These obligations place a large burden on small island states with few resources to commit to developing a strong evidence base for public health policy interventions.

There have been a range of disputes at the WTO over health-related measures that are perceived as technical barriers to trade (Friel et al, 2015).¹¹ PACER Plus includes several countries that are not currently WTO members. These countries are expected to comply with the chapter's WTO level obligations to the extent of their capacity.



Conclusion and recommendations

As a matter of general principle in trade negotiations, ***PHAA calls for transparent trade negotiating practices and for the routine use of independent health, environmental and human rights impact assessment during negotiations.***

The PHAA supports the capacity of Pacific island nations to set their own policy parameters in a democratic manner, and to be able to govern themselves so as to set sound public health policies and effectively to maintain health services. We are unable to be certain that Pacer Plus respects these capabilities.

PHAA therefore recommends that the proposed Australian Pacer Plus implementation legislation be deferred, pending the independent analysis being done on the following matters:


- ***Any immediate and specific impacts on public health policies, services and outcomes in any of the nations involved in PACER Plus that would flow from the terms of the agreement.***
- ***The long-term impact of the Pacer Plus agreement on revenue capacity in the Pacific Island Countries, and any corresponding impacts on health service provision in those nations.***
- ***The extent to which the Pacer Plus agreement would constrain the democratic role of Pacific island nation parliaments in shaping public health policies for their people.***

The conduct of such analysis should also allow for the fulfilment of World Health Organisation Resolution 59.26, which mandates WHO to provide advice to governments regarding the health implications of trade agreements.

This mandate raises a key issue for the PHAA. It is simply unconscionable that Australia would in any way support the ability of country control tariffs on tobacco. The PHAA requests the Committee to assess any impact that challenges and/or “regulatory chill” might have on restricting the ability of governments to implement tobacco control measures. ***The Pacer Plus Agreement must have a broad tobacco exemption.***

Finally, PHAA recommends that either JSCT or a select committee of Parliament should inquire into and report on the general issue of modern trade agreements being used in a manner which overrides the capacity of democratic nations – not limited to small nations, but in regard to Australia as well – to set appropriate public health policies.

The PHAA appreciates the opportunity to make this submission to the JSCT. Please do not hesitate to contact me should you require additional information or have any queries in relation to this submission.



Michael Moore AM
Chief Executive Officer
Public Health Association of Australia

15 February 2018

References

- ¹ World Health Assembly (2006). International trade and health. Resolution 59.26, 27 May 2006.
- ² World Health Organization Framework Convention on Tobacco Control <http://www.who.int/fctc/en/>
- ³ Public Health Association of Australia. Submission to the Foreign Affairs, Defence and Trade Reference Committee on the Commonwealth's treaty-making process, particularly in the light of the growing number of bilateral and multilateral trade agreements, 2015.
- ⁴ World Health Organization Intergovernmental Working Group on Public Health (2007). Draft global strategy and plan of action on public health, innovation and intellectual property; Interagency work on the interface between trade, intellectual property and public health. Geneva, WHO.
- ⁵ Labonte R, Schram A and Ruckert A. (2016) The Trans-Pacific Partnership: Is it everything we feared for health? International Journal of Health Policy and Management, 5(x), 1-10.
- ⁶ Banks et al (2015) Tobacco smoking and all-cause mortality in a large Australian cohort study: findings from a mature epidemic with current low smoking prevalence. BMC Medicine 2015
<https://bmcmmedicine.biomedcentral.com/articles/10.1186/s12916-015-0281-z>
- ⁷ Kelsey, J (2017) Regulatory Chill: Learning from New Zealand's Plain Packaging Tobacco Law. QUT Law Review p21-45
<http://heinonline.org/HOL/LandingPage?handle=hein.journals/qutlj17&div=16&id=&page=>
- ⁸ Smith RD, Chanda R and Tangcharoensathien, V. (2009) Trade in health-related services. The Lancet, 373: 593-601.
- ⁹ Missoni, E. (2013) Understanding the impact of global trade liberalization on health systems pursuing universal health coverage. Value in Health 16: S14-S18.
- ¹⁰ Baunsgaard and Keen (2005) Tax Revenue and (or?) Trade Liberalization. IMF Working Paper WP/05/112. International Monetary Fund.
- ¹¹ Friel S, Hattersley L and Townsend R. (2015). Trade policy and public health. Annual Review of Public Health, 36: 325-44.