Alcohol Healthwatch
Whakatūpato Waipiro

Submission on the International treaty examination of the Trans-Pacific Partnership Agreement

11th March, 2016

Alcohol Healthwatch is an independent charitable trust working to reduce alcohol-related harm. We are contracted by the Ministry of Health to provide a range of regional and national health promotion services. These include: providing evidence-based information and advice on policy and planning matters; coordinating networks and projects to address alcohol-related harms, such as alcohol-related injury, fetal alcohol spectrum disorder, supply to minors; and coordinating or otherwise supporting community action projects.

Thank you for the opportunity to submit on the International treaty examination of the Trans-Pacific partnership agreement (TPPA).

We would appreciate the opportunity to present an oral submission.

If you have any questions on the comments we have included in our submission, please contact:

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1. Introduction

Alcohol Healthwatch acknowledges that there are benefits to New Zealand entering into free trade agreements (FTAs) with other nations. We are not opposed to this.

We are however, concerned about the implications of FTAs in relation to public health, and specifically in relation to reducing the substantial burden of alcohol-related harm.

We are therefore seeking increased protections in FTAs to protect public health and increased resolution by the New Zealand Government to implement evidence-based policy and interventions to reduce alcohol related harm and the associated inequities.

Free Trade Agreements have come under increasing scrutiny by public health interests. Much of the concern stems from the 'Investor State Dispute Settlement' (ISDS) provisions in FTAs.

We recognise most of these agreements contain some '*safeguard measures'* to protect public health however we are aware that despite such measures, significant risks remain.

In this submission we seek to outline the context of our concerns, and to provide examples of the risks. We also make some recommendations for the consideration of the committee.

2. Alcohol and Free Trade Agreements

Alcohol is a leading modifiable risk factor for global burden of disease,[1] and the single leading risk factor for death and disability in young people.[2] It is a causal factor in 60 types of diseases and injuries (intentional and unintentional) and a contributing factor in 200 more.[3]

Alcohol is attributed to a myriad of harms, to name a few, cancer, liver cirrhosis, cardiovascular disease, depression, suicide, family violence, sexual violence, child neglect and abuse, injuries and vandalism, etc.[4] The range and magnitude of harm extends beyond the drinker and the harm experienced by an individual from others' drinking is more significant than previously thought.[5]

The New Zealand Law Commission 2010 report: Alcohol in Our Lives: Curbing the Harm concludes '*New Zealanders have been too tolerant of the risks associated with drinking to excess. Unbridled commercialisation of alcohol as a commodity in the last 20 years has made the problem worse*".

Recent reports show;

- New Zealanders consume more alcohol per capita than the world average.[6]
- One in five past year drinkers have a hazardous drinking pattern.[7]
- While hazardous drinking rates have improved among most population groups, rates continue to increase among 45-54 year olds, and remain unacceptably high among 18-24 year olds (34%) and 15-17 year olds (10%).[8]
- Alcohol consumption is responsible for 5.4% of deaths and 6.5% of disability-adjusted life years lost by New Zealanders under 80 years of age.[9]
- Between 800 and 1000 New Zealanders die from alcohol-attributable causes every year and many thousands more experience physical, emotional, health, disability, social and economic harms from their alcohol use.[10]

- More than half of alcohol-related deaths are due to injuries, one quarter are due to cancer and one quarter are due to other chronic diseases.[11]
- In 2009 the economic cost of the harmful use of alcohol was estimated as $4.9 billion per annum.

The burden of alcohol-related harm falls disproportionately on those most vulnerable, such as those who experience low socio-economic status, Māori, Pacific and young people, and those who are already affected by their own alcohol use or that of others. This makes alcohol a significant factor in inequalities and inequity.

Alcohol has been identified as one of the main modifiable risk factors for Non-Communicable Diseases (NCD) by the World Health Organisation (WHO), alongside tobacco, alcohol and ultra-processed food and drink.[12] These transnational industries are identified as the major drivers of NCD epidemics worldwide.[13]

The World Medical Association (WMA), a global federation of national medical associations representing more than nine million physicians, deliberated global trade policy while adopting their resolution in 2005. They argued that alcohol must be considered an "extra-ordinary commodity".

They recommended that in order to protect current and future alcohol control, measures affecting the supply, distribution, sale, advertising, promotion, or investment in alcoholic beverages be excluded from international trade agreements when they are likely to have a negative impact on public health (particularly when a country is forced to lower its taxes on imported alcohol).[14]

It is therefore incredibly important that independent states and partner states reserve the right to impose appropriate policy and intervention in order to reduce the accessibility and availability of alcohol, restrict its marketing and enable the implementation of harm prevention measures that work to reduce alcohol related harm, but may have an impact on the associated industries.

We recommend that the Committee acknowledge the significant burden of alcohol-related harm in its deliberations and reporting on the TPPA.

3. Protecting public health in TPPA and FTAs

Alcohol Healthwatch applauds the inclusion of some safeguard measures in the TPPA to preserve the *inherent right* to regulate, legislate and protect legitimate public welfare objectives including public health.

We note that in the initial provisions (chapter 1), Parties of the TPPA affirm their existing rights and obligations with respect to the other Parties, in relation to existing international agreements to which all Parties are party, including the WTO Agreement.

Subsequent chapters of TPPA also affirm Parties' commitment to public health. This includes Chapter 8 - Technical Barriers to Trade, Chapter 9 and Annex 9B - Investment, Chapter 18 – Intellectual Property, Chapter 29 – Exceptions and Annex II – New Zealand.

The TPPA has included some specific clauses of WTO Agreement such as the *Declaration on the* Trade-Related Aspects of Intellectual Property Rights (**TRIPS**) *Agreement and Public Health*. We also want to refer, or further elaborate, other clauses of WTO Agreement that relate to regulating public health measures.

The **TRIPS** declaration affirms the Party's right to take measures to protect public health, specifically in relation to access to free medicine. It is also recognised that the Declaration should also be applied to other public health measures, as clearly expressed in the Declaration, '*that the TRIPS Agreement does not and should not prevent measures to protect public health.'*[15]

Article 8.1 of the TRIPS also underpins the flexibility in TRIPS or the *principle* of providing regulatory space for public health:

'Members may, in formulating or amending their laws and regulations, adopt measures necessary to protect public health and nutrition, and to promote the public interest in sectors of vital importance to their socio-economic and technological development, provided that such measures are consistent with the provisions of this Agreement.'

Article XX of the General Agreement on Tariffs and Trade 1994 contains a clause that permits WTO members to adopt measures that are *necessary to protect human health* provided that such '*measures are not applied in a manner which would constitute a means of arbitrary or unjustifiable discrimination between countries where the same conditions prevail, or a disguised restriction on international trade.'*

The importance of public health and the right of states to take regulatory measures are recognised across the *international trade and investment regime.*[16]

In the cases of EC-Asbestos and Brazil Tyres, the WTO's Appellate Body recognised that the '*protection of public health is both vital and important in the highest degree*.'[16] WTO members are entitled to establish their own policy objectives.[16] It is necessary and justifiable to make regulatory measure as a precautionary approach such that the *'benefit'* of the regulatory measure, or when combined with other policies, can be proven over a certain period of time.

While these safeguards for public health offer some protection for countries who decide to implement evidence-based policy interventions. We note however, that while tobacco is a commodity that warrants specific protection in the TPPA, alcohol is not offered similar protections.

We recommend that the TPPA includes specific protections for Parties to allow them to regulate and impose any such policies, regulations and interventions necessary to reduce alcohol-related harm.

4. The 'Chilling Effect'

We are aware that concerns remain that the provisions included in trade treaties to protect a Government's right to regulate to protect public health may not offer enough protection, and that legal loopholes have been used to circumvent these provisions or create a "chilling effect" where fear of litigation prevents nations from implementing effective policies to protect and promote health.

There are examples which validate these concerns, and demonstrate how these provisions have been used by corporations to undermine efforts to protect and promote the health and safety of individuals and the environment. The alcohol and tobacco industries have been known to use judicial tactics to deter a government from adopting new policies or regulations that can hinder their interests.[17]

Examples of how the alcohol and tobacco industry have used Free Trade and similar agreements to undermine efforts to protect public health include:

- Philip Morris Asia has challenged Australia's plain packaging laws under the investor-state dispute settlement (ISDS) provisions set out in an investment treaty between Australia and Hong Kong. Philip Morris Asia is seeking the suspension of enforcement of Australia's plain packaging legislation, or millions of dollars in compensation on the grounds that the value of its investment has been affected by the supposed expropriation of its trademarks and related branding. It is believed that action by Philip Morris Asia is part of a global strategy by the tobacco industry to use international trade and investment dispute mechanisms to undermine evidence-based tobacco control measures.[18]
- The Alcohol Minimum Pricing Bill passed by the Scottish Parliament in 2012 was challenged by the alcohol industry under EU single-market law. The legal process is currently at the European Court of Justice.[19]
- Alcohol marketing and advertising restrictions introduced in France, known as '*The Loi Evin'*, were challenged by alcohol industry stakeholders in the European Court.[20]
- Along with alcohol industry representatives, New Zealand and Australian trade officials joined efforts to thwart Thailand's attempts to introduce graphic warning labels on alcohol containers as a way to address alcohol-related harm.[21]

In addition the broad public health safeguards do not address the impact of FTAs in relation to dimming a Government's enthusiasm and commitment to actively pursuing effective policy interventions.

The globalisation of the alcohol industry over the past decade has transformed not only the structure of alcohol production and distribution, but also the nature of alcohol marketing. The size and profitability of these companies supports integrated marketing on a global scale, as well as allowing considerable resources to be devoted directly or indirectly to promoting the policy interests of the industry.[22]

In the local context , in the New Zealand Herald (6 February 2106) political reporter Audrey Young notes that "*The wine industry will be one of the clearest winners from TPP if it is ratified in two years, with an estimated $10 million in tariffs to come off the $839 million of wine exported to TPP countries*".

The New Zealand Government is less likely, we would propose unlikely, to impose tax increases to increase the price of alcohol or marketing restrictions on alcohol, as it would not want its products to be subject to such restrictions in export markets. This threat is already very tangible.

The New Zealand Government rejected calls by the New Zealand Law Commission to increase excise tax, and ignored recommendations by both the Law Commission and its own appointed

Ministerial Forum on Alcohol Advertising and Sponsorship to restrict alcohol marketing. The Forum reported to Government in October 2014, making a number of recommendations particularly in relation to restriction of alcohol sponsorship of sports to reduce exposure of young people to alcohol marketing.

We recommend that the Committee considers ways to ensure that New Zealand remains free to actively pursue an evidence-based policy agenda to reduce alcohol-related harm, and protect and promote public health, without impediment associated with trade and economic gain.

5. Political Commitment and international instruments to regulate Alcohol and other Non-Communicable Disease (NCDs) risk factors

There is a growing commitment to combat NCDs at global level including the underlying modifiable risk factors – alcohol use, tobacco use, unhealthy diet and physical activity. Progress has been made and the policy issue has been discussed beyond the World Health Organisation (WHO) to the United Nation (UN).

In 2000, the World Health Assembly of the WHO adopted the *Global Strategy for the Prevention and Control of Non-communicable Diseases.*

In 2011, the General Assembly of the UN adopted a resolution on NCD during the high-level meeting of NCDs.[23]

The resolution noted the need for a multi-sectoral response to combat NCDs, at regional, national and global level, being aware that the risk factors have economic, social, gender, political, behavioural and environmental determinants.

In May 2013, the World Health Assembly endorsed the *Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013-2010*.[24]

In July 2013, the UN Economic and Social Council requested the UN Secretary-General to establish the UN Interagency Task Force on the Prevention and Control of NCDs.[25]

The Action Plan outlined the strategies to reduce the preventable burden of NCDs and restated the importance of multi-sectoral collaboration at every level in order to attain the highest standards of health and productivity at every age.

In 2015, the UN included the target to reduce one-third of premature mortality from NCDs through prevention and treatment in their Sustainable Development Goals 2030 (Article 3.4).[26] Article 3.5 called for strengthening the prevention and treatment of substance abuse including harmful use of alcohol. [27]

- ***The rationale for regulating alcohol use within the context of rights-based approach***

Given the role alcohol has on increasing inequalities and inequities in health, attention must also be drawn to relevant international treaties in regards to human rights.

The *International Convention on Economic, Social and Cultural Rights* stated in Article 12.1 that everyone have the right *'to the enjoyment of the highest attainable standard of physical and mental health'.*

This also includes The *United Convention on the Rights of the Child (UNCRoC), in particular* Article 24 - Right to Health, Article 17- Right to Information and Article 32 - Freedom from Exploitation.

In 2010, the World Health Organization adopted the *Global Strategy to Reduce the Harmful Use of Alcohol.*[28]

While these instruments may not be legally binding an author of the book – *Regulating Tobacco, Alcohol and Unhealthy Foods: The Legal Issues, argues that such non-binding instruments should be seen as 'having the capacity to significantly inform the way in which trade investment treaties, with all of their flexibilities, are interpreted and applied.'*[29] We agree wholeheartedly.

We recommend that the Committee include in its report reference to these important international agreements and instruments, binding or non-binding, and seek a review of the TPPA in light of these.

We recommend that Health Impact Assessments are conducted to monitor the impact of TPPA on health.

6. Conclusion

We echo the principle and positions identified by the Public Health Association of Australia and New Zealand:

- A fair regime of regulating trade, investment and intellectual property ('trade and investment agreements) should priorities health and social and ecological sustainability as well as economic development.
- Trade and investment agreements, and their dispute settlement mechanisms, should be consistent with international law in regard to health, human rights, the environment and work protection.
- Trade and investment agreements must prioritise equity within and between countries for global population health improvement.

To address the significant burden of alcohol-related harm, New Zealand requires a comprehensive multi-level response requiring the introduction of a range of evidence-based alcohol harm reduction policies and interventions.

This requires cross-sector and inter-sectoral approaches whereby for example health and trade outcomes receive fair and equitable consideration.

Alongside the safeguard measures to protect the policy space of public health measures New Zealand should take a proactive approach to actively engage in the dialogue of making evidence-based regulation to reduce alcohol use and other NCD factors.

Summary of Recommendations:

1. **We recommend that the Committee acknowledge the significant burden of alcohol-related harm in its deliberations and reporting on the TPPA.**

2. **We recommend that the TPPA includes specific protections for Parties to allow them to regulate and impose any such policies, regulations and interventions necessary to reduce alcohol-related harm.**

3. **We recommend that the Committee considers ways to ensure that New Zealand remains free to actively pursue an evidence-based policy agenda to reduce alcohol-related harm, and protect and promote public health, without impediment associated with trade and economic gain.**

4. **We recommend that the Committee include in its report reference to these important international agreements and instruments, binding or non-binding, and seek a review of the TPPA in light of these.**

5. **We recommend that Health Impact Assessments are conducted to monitor the impact of TPPA on health.**

References

[1] Lim SS, Vos T, Flaxman AD, et al. 2012. A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet 380:2224–60.

[2] Gore FM, Bloem PJN, Patton GC, et al. 2011. Global burden of disease in young people aged 10–24 years: a systematic analysis. Lancet 377:2093–102.

[3] World Health Organization. 2011. Global status report on alcohol and health. Geneva: World Health Organization.

[4] Babor T, Caetano R, Casswell S, et al. 2010. Alcohol: No ordinary commodity. New York: Oxford University Press.

[5] Connor J, Casswell S. 2012. Alcohol-related harm to others in New Zealand: evidence of the burden and gaps in knowledge. The New Zealand Medical Journal 125(1360):11-27.

[6] World Health Organization. 2011. Global status report on alcohol and health. Geneva: World Health Organization.

[7] Ministry of Health. 2013. Hazardous drinking in 2011/12: Findings from the New Zealand Health Survey (HP 5640). Wellington: Ministry of Health.
Hazardous drinking is defined as a score of 8 points or more on the 10-question Alcohol Use Disorders Identification Test (AUDIT), which includes questions about alcohol use, alcohol-related problems and abnormal drinking behaviour. Hazardous drinking refers to an established drinking pattern that carries a risk of harming the drinker's physical or mental health, or having harmful social effects on the drinker or others.

[8] Ministry of Health 2015. Annual Update of Key Results 2014/15 New Zealand Health Survey. Wellington Ministry of Health.

[9] Connor J, Kydd R, Rehm J, Shield K. 2013. Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007. Wellington: Health Promotion Agency.

[10] Connor J, Broad J, Jackson R, et al. 2005. The burden of death, disease, and disability due to alcohol in New Zealand. Wellington: Alcohol Advisory Council of New Zealand.

[11] Connor J, Broad J, Jackson R, et al. 2005. The burden of death, disease, and disability due to alcohol in New Zealand. Wellington: Alcohol Advisory Council of New Zealand.

[12] Moodie, R., Stuckler, D., Monteiro, C., et al. Lancet NCD Action Group. (2013). Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. *The Lancet*, *381*(9867), 670-679.

[13] Liberman J. 2014. Making effective use of law in the global governance of NCD prevention. In Voon T, Mitchell AD & Liberman J *Eds.), *Regulating Tobacco, Alcohol and unhealthy foods: the legal issues* (1st ed., pp 12-35). Abingdon, Oxon United Kingdom; New York, NY: Routledge.

[14] World Medical Association. 2005. Statement on Reducing the Global Impact of Alcohol on Health and Society." 56th WMA General Assembly. Santiago, Chile.
http://www.wma.net/en/30publications/10policies/a22/ (accessed 10 March 2016).

[15] Zhou S. 2014. *The Doha Declaration: for prevention as well as cure.* http://www.mccabecentre.org/blog-main-page/doha-declaration.html (accessed 9 March, 2016).
Davison M, Liberman J, Mitchell A. 2014. *Responding to the tobacco industry's claims that plain packaging breaches international trade 16and investment law. http://www.mccabecentre.org/blog-mainpage/respondingtothetobaccoindustrysclaims.html* (accessed 9 March, 2016).

[16] Davison M, Liberman J, Mitchell A. 2014. *Responding to the tobacco industry's claims that plain packaging breaches international trade 16and investment law. http://www.mccabecentre.org/blog-mainpage/respondingtothetobaccoindustrysclaims.html* (accessed 9 March, 2016)

[17] Kelsey, J. 2012. New-generation free trade agreements threaten progressive tobacco and alcohol policies. Addiction 107:1719-1721.

[18] Gleeson D, Fried S. 2013. Emerging threats to public health from regional trade agreements. The Lancet 381: 1507-09.

[19] Alcohol Focus Scotland. 2015. Minimum Pricing. http://www.alcohol-focus-scotland.org.uk/campaigns/minimum-pricing.aspx (accessed 20 April, 2015).
Scotsman. 2012. Minimum pricing by next spring but move still faces legal challenge. http://www.webcitation.org/6L4xGezFg (accessed 20 April, 2015).

[20] Johansen I. (2009). *Loi Evin – an advertising ban in the Homeland of Red Wine*. http://www.stap.nl/content/bestanden/loi-evin_-article-ina.pdf (accessed 20 April, 2015).
[21] Kelsey J. 2012. The implications of new generation free trade agreements for alcohol policies. Paper to the Global Alcohol Policy Conference, Bangkok (February 2012). http://www.converge.org.nz/watchdog/29/08.htm (accessed 20 April, 2015).
Hopkins A. 2014. Trade criticises Thailand alcohol warning labels. http://www.thespiritsbusiness.com/2014/10/trade-criticises-thailand-alcohol-warning-labels/ (accessed 10 march 2016).
[22] Babor T, Caetano R, Casswell S, et al. 2010. Alcohol: No ordinary commodity. New York: Oxford University Press.
[23] UN General Assembly. 2011. Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. United Nations. A/66/L.1. Sept 16, 2011. http://daccess-dds-ny.un.org/doc/UNDOC/LTD/N11/497/77/PDF/N1149777.pdf?OpenElement (accessed 20 April, 2015).
[24] World Health Organization. 2010. Global action plan for the prevention and control of NCDs 2010 -2020. Geneva: World Health Organization.
[25] United Nationals Interagency Task Force on the Prevention and Control of Non-communicable Diseases, ESC Res 2013/L.23, Agenda Item 7(g), UN Doc E/2013/L.23 (12 July 2013).
[26] UN. 2015. Goal 3. Ensure healthy lives and promote well-being for all at all ages. *Sustainable Development Knowledge Platform*. (accessed 10 March 2016)
[27] UN General Assembly. 2011. Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. United Nations. A/66/L.1. Sept 16, 2011. http://daccess-dds-ny.un.org/doc/UNDOC/LTD/N11/497/77/PDF/N1149777.pdf?OpenElement (accessed 20 April, 2015).
[28] World Health Organization.2010. Global Strategy to reduce the harmful use of alcohol. Geneva: World Health Organization.
[29] Liberman J. 2014. Making effective use of law in the global governance of NCD prevention. In Voon T, Mitchell AD & Liberman J *Eds.), *Regulating Tobacco, Alcohol and unhealthy foods: the legal issues* (1st ed., pp 12-35). Abingdon, Oxon United Kingdom; New York, NY: Routledge.