



**Public Health Association**  
AUSTRALIA

## **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*

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## Introduction

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles. The PHAA has a vision for a healthy region, a healthy nation and healthy people living in a healthy society and a sustaining environment while improving and promoting health for all.

### Public Health

Public health includes, but goes beyond the treatment of individuals to encompass health promotion, prevention of disease and disability, recovery and rehabilitation, and disability support. This framework, together with attention to the social, economic and environmental determinants of health, provides particular relevance to, and expertly informs the Association's role.

### The Public Health Association of Australia

PHAA is a national organisation comprising around 1900 individual members and representing over 40 professional groups concerned with the promotion of health at a population level.

Key roles of the organisation include the development of policy, capacity building and advocacy. Core to our work is an evidence base drawn from a wide range of members working in public health practice, research, administration and related fields who volunteer their time to inform policy, support advocacy and assist in capacity building within the sector. PHAA supports a preventive approach for better population health outcomes by championing appropriate policies and providing strong support for Australian governments and bodies such as the National Health and Medical Research Council in their efforts to develop and strengthen research and actions in public health. The PHAA is an active participant in a range of population health alliances including the *Australian Health Care Reform Alliance*, the *Social Determinants of Health Alliance*, the *National Complex Needs Alliance* and the *National Alliance for Action on Alcohol*.

PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. The Branches work with the National Office in providing policy advice, in organising seminars and public events and in mentoring public health professionals. This work is based on the agreed policies of the PHAA. Our Special Interest Groups provide specific expertise, peer review and professionalism in assisting the National Organisation to respond to issues and challenges as well as providing a close involvement in the development of policies. In addition to these groups the PHAA's Australian and New Zealand Journal of Public Health (ANZJPH) draws on individuals from within PHAA who provide editorial advice, and review and edit the Journal.

### Advocacy and capacity building

In recent years PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all levels of governments and agencies, and promoting key policies and advocacy goals through the media, public events and other means.

## Preamble

PHAA welcomes the opportunity to provide input to the Standing Committee on Foreign Affairs, Defence and Trade Reference on the Commonwealth's treaty-making process, particularly in the light of the growing number of bilateral and multilateral trade agreements. The reduction of social and health impacts and particularly inequities should be an overarching goal of national policy and recognised as a key measure of our progress as a society. The Australian Government should take this into account in the negotiation of all international treaties. Treaties, along with all public health activities and related government policy should be directed towards reducing social and health inequity nationally as well as internationally.

### Health Equity

As outlined in the Public Health Association of Australia's objectives:

*Health is a human right, a vital resource for everyday life, and a key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions of society that underpin people's health. The health status of all people is impacted by the social, political, and 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.*

The PHAA notes that:

- health inequity differs from health inequality. A health inequality arises when two or more groups are compared on some aspect of health and found to differ. Whether this inequality (disparity) is inequitable, however, requires a judgement (based on a concept of social justice) that the inequality is unfair and/or unjust and/or avoidable. Inequity is a political concept while inequality refers to measurable differences between (or among, or within) groups.
- Health inequity occurs as a result of unfair, unjust social treatment – by governments, organisations and people, resulting in macro politico-economic structures and policies that create living and working conditions that are harmful to health, distribute essential health and other public services unequally and unfairly, preventing some communities and people from participating fully in the cultural, social or community life of society.

### Social Determinants of Health

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

The determinants of health inequities are largely outside the health system and relate to the inequitable distribution of social, economic and cultural resources and opportunities. Health inequities are the result of the interaction of a range of factors including: macro politico-economic structures and policy; living and working conditions; cultural, social and community influences; and individual lifestyle factors. International trade has the potential to have a major impact on health inequity in Australian and elsewhere.

# Response to the Commonwealth's treaty-making process inquiry

## a) The Public Health Association of Australia's policy on trade agreements and public health

PHAA has a policy on trade agreements and health which can be found here:

[http://www.phaa.net.au/documents/120130\\_Trade%20Agreements%20&%20Health%20Policy%20FINAL-with%20cover%20sheet.pdf](http://www.phaa.net.au/documents/120130_Trade%20Agreements%20&%20Health%20Policy%20FINAL-with%20cover%20sheet.pdf)

Alternatively: The PHAA Website: [www.phaa.net.au](http://www.phaa.net.au) may be searched under "Policy".

The policy states that:

1. Trade agreements should not limit or override a nation's ability to foster and maintain systems and infrastructure that contribute to the health and well-being of its citizens by detracting from a nation's ability to legislate and regulate in the national interest;
2. Policy space needs to be preserved in trade agreements for national governments to regulate to protect public health; and
3. PHAA advocates a fairer regime of trade regulation which addresses sustainability issues as well as economic development and which prioritises equity within and between countries as a necessary condition for global population health improvement.

The policy also commits the association to "advocate at the national and international levels to promote and protect public health within international trade agreements and limit adverse impacts of trade agreements on health and well-being, both within Australia and in other countries."

## b) Our concerns about the potential impact of trade agreements on public health

Trade agreements are a significant determinant of health. They can affect many aspects of health care and public health. These include <sup>(1, 2)</sup>:

- access to affordable medicines;
- the equitable provision and quality of health care services;
- the ability of governments to regulate health damaging products such as tobacco, alcohol and processed foods;
- the nutritional status of populations; and
- access to many of the social determinants of health such as employment and income.

Our members are particularly concerned about a new emerging breed of trade agreements that aims to extend further 'behind the border' into areas that have previously been matters for domestic policy making. These include the Trans Pacific Partnership Agreement negotiations to which Australia is a party.

In relation to the **Trans Pacific Partnership Agreement (TPP)**, we are aware that proposals under discussion have included, among others <sup>(3)</sup>:

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- expanded intellectual property rights and constraints on operation of the Pharmaceutical Benefits Scheme (PBS) that would increase medicine costs for both Government and the Australian community;
- an investor-state dispute settlement (ISDS) mechanism that would enable foreign corporations to sue Australian governments over their health related policies and laws (a similar mechanism to that utilised by Philip Morris Asia to sue Australia over tobacco plain packaging);
- provisions that would provide greater rights to industry to participate in policy making processes.

Australia is one of 24 governments who since 2012 have been negotiating (in secret) the **Trade in Services Agreement** <sup>(4)</sup>. It is widely understood that the main drivers behind this proposed agreement are the transnational financial corporations who are seeking to reduce national barriers to their seamless global operations. A leaked text of the Financial Services chapter <sup>(5)</sup> (dated 14 April 2014) includes a range of provisions which have been interpreted (Kelsey<sup>(6)</sup>) as locking in the liberalised deregulated global financial services regime which led to the 2007 Global Financial Crisis. Kelsey argues that the rules envisaged in the leaked text would target:

- limits on the size of financial institutions (too big to fail);
- restrictions on activities (eg deposit taking banks that also trade on their own account);
- requiring foreign investment through subsidiaries (regulated by the host) rather than branches (regulated from their parent state);
- requiring that financial data to be held onshore;
- limits on funds transfers for cross-border transactions (e-finance);
- authorisation of cross-border providers;
- disclosure requirements on offshore operations in tax havens;
- certain transactions must be conducted through public exchanges, rather than invisible over-the-counter operations;
- approval for sale of 'innovative' (potentially toxic) financial products;
- regulation of credit rating agencies or financial advisers;
- controls on hot money inflows and outflows of capital;
- requirements that a majority of directors are locally domiciled;
- authorisation and regulation of hedge funds; etc.

Such rules would be policed through investor state dispute settlement and locked in through extreme penalties for withdrawal.

While such deregulation might promise benefits for large financial corporations it is highly debatable that they are all in the public interest. In view of the political influence that large financial corporations exercise, in Australia and elsewhere, the secrecy and lack of public engagement regarding the core policy issues is very dangerous.

In February 2015 a leaked concept paper on health care services which had been tabled by Turkey in Sept 2014 was published <sup>(7)</sup>. The concept paper is directed to promoting 'medical tourism' through agreed rules regarding health insurance. Health care providers in the receiving country would be approved by an authority in the sending country. Insurers would be expected to cover travel costs

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and the costs of treatment up to the cost of such treatment in the home country. The host country 'bears the responsibility of any necessary care after the treatment'.

The concept of using trade in services rules to promote such off shoring of medical treatment appears to have originated in the US where it was offered <sup>(8)</sup> as a strategy for reducing the cost of health care in the US.

This proposal could have huge repercussions for both the sending and the receiving countries. In Australia both Medicare and private health insurers would be obligated to pay benefits for medical tourism with very uncertain guarantees of quality. There is ample evidence from receiving countries that medical tourism creates an internal brain drain, for example, away from publicly provided primary health care clinics into large private hospitals.

Medical tourism is already happening. However, including these rules in TISA would obligate states parties to legislate for such a system with very high barriers to withdrawal and policed through investor state dispute settlement.

The secrecy of these negotiations precludes community discussion of the risks of such a scheme. The lobbying power of the hospital and insurance corporations carries the risk that the negotiators will be mistake corporate interest for national interest.

In relation to **PACER Plus**, the Pacific Agreement on Closer Economic Relations, we are concerned about the effects this may have on the capacity of pacific island countries to provide primary health care and public health services. Tariff reductions proposed in the negotiations of PACER PLUS initiated by Australia could result in reduced government revenue for health in several island countries<sup>(9)</sup>. Such moves contradict key health objectives in the region, such as the goal of a malaria-free Asia Pacific by 2030. We are also concerned that the agreement will enable challenges to public health regulation, including current import restrictions on high fat and sugar foods in the pacific, and that the agreement may enable further health workforce 'brain drain' from islands to Australia and New Zealand <sup>(10)</sup>.

Our concerns about the **Regional Comprehensive Economic Partnership (RCEP)** centre on the threat to access to medicines in the Asia Pacific region. Leaked text tabled by Japan contains intellectual property provisions that, if Australia and the other fourteen countries in our region agree to, could delay the entry of cheaper generic medicines. The Japanese proposal includes IP provisions that are more stringent than Australia's IP law that could weaken the public interest balance. Like the TPP, the RCEP is wide ranging and includes several other chapters that impact on health, including trade in services, investment, economic and technical cooperation, competition, dispute settlement and other issues related to government regulation. We have no access to other chapters of the negotiating texts which has not been made public.

Our association has engaged in many discussions with the Department of Foreign Affairs and Trade and has written many letters and submissions over the past few years to highlight the potentially health-damaging effects of trade negotiations, particularly negotiations for the TPP. We have also repeatedly expressed concern about the treaty-making process and in particular the lack of transparency in the negotiations.

### **c) The need for transparency and independent analysis of trade agreements before treaties are signed**

It is inevitable that tensions arise between the interests of large transnational corporations and the broader national polity, the public interest. It is unfortunate but also true that corporate lobbyists have privileged access to and disproportionate influence over political parties and leaders. Many of the most powerful lobbyists are representing overseas owned transnationals whose ultimate obligation is to their overseas shareholders. In these circumstances the secrecy and lack of transparency of trade negotiations represents a serious threat to the public interest.

We have been assured many times that the Australian Government is pursuing the interests of Australians in the trade negotiations (e.g. in the TPP) and that it will not accept provisions that will compromise the health system or access to generic medicines.

However, there are several issues that make us wary of these general reassurances, particularly in relation to the TPP:

- PHAA includes members who are expert in assessing the health implications of policies (including policies outside of the health sector) and experts in the links between trade and health. Our members are very well aware that when it comes to legal treaty text, “the devil is in the detail”. The exact wording is critically important. Because we cannot see the proposed wording, our expert members cannot make an independent assessment of the potential consequences on the health of Australians.
- In many areas of the TPP negotiations, the United States has set the agenda and tabled the text, in many cases based on its own domestic law, which becomes a starting point for the negotiations. The US health system is characterised by high costs to consumers and low levels of access. This is antithetical to the values of universal access on which our health system is based. US corporations also have privileged access to the text and strong influence over its contents through a set of trade advisory committees. The US proposals that have been leaked show the text is heavily weighted in the interests of corporations rather than the public.
- Trade negotiations involve bargaining, and health sector interests can often be traded off in exchange for wins in other areas. Our Prime Minister Tony Abbott has referred to the “horse trading” that inevitably takes place in the negotiating context.

### **d) Logic of bilateral and plurilateral trade negotiations; the cost of by passing multilateralism**

It is important to recall the history of the shift in policy focus from multilateralism to the current paradigm under which bilateral and plurilateral agreements are negotiated among willing partners but outside parties are then pressured to join under ‘take it or leave it’ conditions.

The breakdown of the Doha round of WTO negotiations arose from the refusal of certain powerful rich countries to liberalised trade in agriculture even while demanding that developing countries should open their markets to manufactured imports.

There are important health policy issues at stake in negotiations where the interests of poor people in developing countries are pitted against the interests of large transnational corporations largely

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owned in the US, Europe and Japan. An illustrative case is the debate over the seizure of medicines in transit on the grounds of alleged breaches of intellectual property rights. This is a direct attack on generic manufacturers and on the legislative regimes which allow them to compete with proprietary brand name drugs.

The TRIPS Agreement was achieved through multilateral negotiations where developing countries were able to argue to a compromise between the pharmaceutical industry and access to treatment. Australia, as a net importer of IP, has no national interest in siding with the proprietary pharmaceutical companies against the treatment access movement. However, the secretive plurilateral model excludes such considerations from the policy making which frames Australia's participation in trade negotiations.

### **e) Responses to the Committee's Terms of Reference**

We wish to respond to the committee's TORs f, g, h and j.

#### **f. The scope for independent assessment and analysis of treaties before ratification**

At present it is extremely difficult to access information about the specifics of the issues being discussed in trade negotiations. While we appreciate the efforts of Australia's trade negotiators (within the constraints of their mandate) to share general information about the status of negotiations and Australia's positions on key issues of interest to us, we continue to be frustrated by the lack of detail provided and our lack of access to negotiating text. This severely limits the ability of our Association and its expert members to assess the implications of trade treaties.

PHAA has led a health impact assessment of the Trans Pacific Partnership Agreement negotiations, and the final report will be published very soon. However, we have had to base this assessment on leaked draft documents (some of which are now very old) and to build scenarios based on reasonable assumptions about what may be in the agreement. This is far from ideal.

We are very concerned that the text of trade agreements is not released publicly before being signed by Cabinet. **We strongly advocate for release of treaty text for public and Parliamentary scrutiny before signing.**

#### **g. the scope for government, stakeholder and independent review of treaties after implementation**

Given the significant impact that trade agreements can have on many aspects of health, **we believe it is essential that health impact assessment of all treaties be undertaken during negotiation, after final agreement is reached and after implementation.**

#### **h. the current processes for public and stakeholder consultation and opportunities for greater openness, transparency and accountability in negotiating treaties**

The current process for public and stakeholder consultation is very ad hoc. There should be requirements for trade negotiators to systematically consult with stakeholders. Position papers and composite drafts of treaty texts should be released at key points during the negotiations.

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### j. exploration of what an agreement which incorporates fair trade principles would look like, such as the role of environmental and labour standard chapters

A fair trade agreement would:

- Be negotiated in an open and transparent fashion, with publication of government positions on key issues of public interest and negotiating drafts at key points in the negotiations, systematic consultation with health experts, and independent health and human rights impact assessments conducted before government commits to its terms;
- Include strong exceptions for public health and other language ensuring that public health takes precedence over trade issues;
- Not expand intellectual property protections beyond those in the World Trade Organization's TRIPS Agreement;
- Not provide greater rights to corporations to participate in policy making processes or to challenge governmental action in relation to public health;
- Give due weight to the health and welfare of poor people in low and middle income countries.

## Recommendations

This submission from the PHAA recommends to the Standing Committee to:

1. Ensure that treaty text is released before being signed by the Cabinet, in sufficient time for independent assessment of the implications before it is finalised.
2. Make health impact assessments mandatory during negotiation, after release of the final agreement and after implementation.
3. Put in place processes for systematic consultation and for release of position papers and composite drafts of treaty texts at key points during the negotiating process.
4. Ensure that treaty text prioritises health in areas where health may conflict with trade goals.

## Conclusion

The PHAA appreciates the opportunity to make this submission and looks forward to the possibility of further participation in the inquiry on the Commonwealth's treaty-making process, particularly in the light of the growing number of bilateral and multilateral trade agreements

Please do not hesitate to contact the PHAA should you require additional information or have any queries in relation to this submission.



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