

**Comments Concerning Proposed
United States-Trans-Pacific Partnership Trade Agreement**

Docket: USTR-2009-0041

Office of the United States Trade Representative

January 25, 2010

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CPATH ♦ Center for Policy Analysis on Trade and Health

Bringing a Public Health Voice to Trade and Sustainable Development

January 25, 2010

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United States Trade Representative
Executive Office of the President
600 17th Street NW
Washington, DC 20208

Re: Comments Concerning Proposed United States-Trans-Pacific Partnership Trade Agreement

CPATH thanks the Office of the United States Trade Representative for providing the opportunity to submit comments on the United States-Trans-Pacific Partnership Trade Agreement.

USTR has requested public input on the direction, focus, and content of Trans-Pacific Partnership negotiations. Initial TPP negotiating partners include Australia, Brunei Darussalam, Chile, New Zealand, Peru, Singapore and Vietnam, with the objective of including additional countries throughout the Asia-Pacific region.

CPATH has been involved for many years in bringing a public health voice to the debate on trade and sustainable development through research, policy analysis, and advocacy. Our comments on the proposed United States-Trans-Pacific Partnership Trade Agreement reflect a public health perspective. We will assess how and to what extent previous FTAs with Australia, Chile, Peru, and Singapore have made progress in achieving Public Health Objectives for Global Trade, a set of objectives that would promote and protect health and sustainable economic development. Unfortunately in most of these trade negotiations, advice to USTR from US Trade Advisers representing industries associated with public health and health care – pharmaceuticals, tobacco, alcohol, health insurance, and process food – has been influential in shaping US trade objectives and negotiating positions, while relevant new and emerging issues related to public health have been overlooked or not considered.

We want to ensure that the injuries to public health are not perpetuated by this new round of trade negotiations. Rather, we will recommend robust objectives for the TPP Trade Agreement negotiations that will safeguard the health of Americans and our trading partners, and promote economically and socially just, democratically controlled, and environmentally sustainable outcomes.

In our comments, we discuss issues of particular recent concern for both trade and health:

- 1. Intellectual Property Rules and access to affordable medicines**
- 2. Tobacco Control and Protection of Public Health**
- 3. Trade in Services and the Nation's Health**

Other public health concerns at issue, which we do not discuss in detail, include the ability of local, state and national governments to regulate clean and safe air, water, food, consumer products; workplace environments, transportation systems; whether government procurement contracts can

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specify standards for medical and financial privacy, quality and performance, local economic development, and environmental protection; and the distribution of alcohol beverages.

In order to address public health concerns, CPATH recommends the following:

Public Health Objectives for the United States-Trans-Pacific Partnership Trade Agreement

1. **To assure democratic participation by public health and transparency in trade policy** by:
 - a. Appointing to all three tiers of trade advisory committees representatives of organizations that work to assure equitable access to affordable health-related services and products, and promote the health of individuals, communities and populations, who can provide formal advice to USTR from the public health and health care community to USTR.
 - b. Opening all proceedings and documents of the trade advisory committees regarding the TPP to the public, and
 - c. USTR consulting with all relevant committees of the House and Senate in the development, negotiation, implementation, and administration of trade and negotiating objectives and positions for the TPP.
2. **To develop mutually beneficial trade relationships with TPP partners that create sustainable economic development** for the U.S. and our trade partners in an increasingly interdependent world.
3. **To recognize the legitimate exercise of national, regional and local government sovereignty to protect population health**, and to ensure that countries do not weaken or reduce, as an encouragement for trade, sound policies that contribute to health and well being, including laws on public health, the environment and labor.
4. **To exclude tariff and nontariff provisions in the TPP that address vital human services** such as health care, water supply and sanitation, food safety and supply, and education, including licensing and cross-border movement of personnel in these fields.
5. **To exclude tobacco and tobacco products**, which are lethal, and for which the public health goal is to reduce consumption, from tariff and nontariff provisions of the TPP, including advertising, labeling, product regulation and distribution.
6. **To exclude alcohol products**, which present serious hazards to public health. Policies designed to reduce the harm caused by alcohol products should not be subject to compromise in exchange for other trade benefits.
7. **To eliminate intellectual property provisions related to pharmaceuticals from TPP negotiations**, as these are more appropriately addressed in multilateral fora, **and promote trade provisions which enable countries to exercise all flexibilities provided by the Doha Declaration on Public Health**, including issuing compulsory licenses for patented pharmaceuticals, parallel importation, and other measures that address high prices and promote access to affordable medicines.

Sincerely,

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Overview and Introduction

USTR has requested public input on the direction, focus, and content of Trans-Pacific Partnership negotiations. Initial TPP negotiating partners include Australia, Brunei Darussalam, Chile, New Zealand, Peru, Singapore and Vietnam, with the objective of including additional countries throughout the Asia-Pacific region. A key objective of the TPP Agreement is the shaping a high-standard, broad-based regional pact.

The Center for Policy Analysis on Trade and Health (CPATH) is an independent organization dedicated to improving population health and expanding access to public health and vital human services, through research, policy analysis and advocacy. CPATH welcomes the opportunity to submit comment on the United States-Trans-Pacific Partnership Trade Agreement.

CPATH has been involved in bringing a public health voice to the debate on trade and sustainable development through research, policy analysis, and advocacy for many years.

The trade landscape has changed dramatically since the 1980s. The pace and number of cross-border transactions have accelerated, though moderated by the current financial slowdown. The chain of production and consumption of goods frequently crosses borders. Services from finance to health care are major economic drivers in developed countries.

Transnational corporations have become more concentrated. Millions in poor countries have emerged from poverty, at the same time that economic inequality is increasing among and within nations.

Trade agreements establish countries' mutual rights and obligations with regard to trade. Once focused on setting tariffs on goods, they now address rules that govern critical areas that are a matter of public debate at the national and international levels: intellectual property rules on access to medicines and to information; services ranging from banking to health care and water supply; government procurement for grants and contracts; and agriculture. They can provide a basis for altering domestic U.S. laws and policies, as well as those of our trading partners. Trade rules must balance between protecting corporations' ability to operate within uniform and predictable rules, and the obligations of governments to protect the public's safety and wellbeing.

Trade agreements can foster sustainable economic development, democracy, and peace, consistent with public health principles that prioritize achieving and protecting the health and wellbeing of individuals, communities and populations.^{1 2} They can also conflict with or subordinate policies that prioritize people's health, and equitable access to health-related services.

Our comments on the proposed United States-Trans-Pacific Partnership Trade Agreement reflect a public health perspective. **Public health views are essential to assure that the rapidly transforming global economy improves people's lives.**

¹Institute of Medicine. The future of public health in the 21st century. National Academies Press, Washington, DC. November, 2002. <http://www.iom.edu/Object.File/Master/4/165/0.pdf>

²World Health Organization. Constitution of the World Health Organization.

In our comments, we will:

I. Assess democratic participation by public health and transparency in U.S. trade policy.

II. Assess how and to what extent previous FTAs with Australia, Chile, Peru, and Singapore have made progress in achieving Public Health Objectives for Global Trade, a set of objectives developed broadly by the public health and health care community in the United States that would promote and protect health and sustainable economic development. In this section, we will address the following issues:

1. Intellectual Property Rules and access to affordable medicines
2. Tobacco Control and Protection of Public Health
3. Trade in Services and the Nation's Health

Other public health concerns at issue, which we do not discuss in detail, include the ability of local, state and national governments to regulate clean and safe air, water, food, consumer products; workplace environments, transportation systems; whether government procurement contracts can specify standards for medical and financial privacy, quality and performance, local economic development, and environmental protection; and the distribution of alcohol beverages.

III. Recommend robust Public Health Objectives and specific goals for the Trans-Pacific Partnership agreement negotiations that will safeguard the health of Americans and our trading partners, and promote economically and socially just, democratically controlled, and environmentally sustainable outcomes.

I. Assessing democratic participation by public health and transparency in U.S. trade policy.

An extensive group of advisory committees provide formal recommendations to the Office of the U.S. Trade Representative (USTR). In 2002, the United States Government Accountability Office (then the General Accounting Office) examined the role, structure, and system of the trade advisory committee system. **The GAO Report found that “new stake holders in the trade process, such as public health...have limited or no participation in the formal committee system, even though topics such as intellectual property are of interest to them.”**³

Health-related industries are robustly represented on US trade advisory committees, which including pharmaceuticals, tobacco, health insurance, processed foods, and alcohol beverages. A public health presence on all three tiers of U.S. trade advisory committees is required for a legitimate balance of interests. However, the lack of Public Health Representation on trade advisory committees is endemic.

In November, 2003, U.S. health leaders called for caution in negotiating international trade agreements. Former U.S. Surgeon General Dr. David Satcher, joining representatives from the American Medical Association, American Nurses Association, the American Public Health Association, and the Center for Policy Analysis on Trade and Health (CPATH), to issue an historic “Call for Public Health Accountability in International Trade Agreements.”

³ GAO-02-876, p. 60; P.L. No. 96-39, 93 Stat. 308-10, p.40.

During the 2004 Congressional deliberations on the US-Australia Free Trade Agreement (FTA), members of the House and Senate expressed concerns about the extreme imbalance on trade advisory committees and lack of representation from public health. Congress raised objections to provisions in the agreement related to pharmaceuticals and intellectual property that they had been unaware of that could have an impact on Congressional efforts to authorize re-importation of drugs. They also expressed concern about the potential impact on current U.S. health care programs, including on Veterans Affairs, Medicare and Medicaid, and urged that such provisions should not serve as precedent for future trade agreements.

On the effect of the imbalance on the trade advisory committees on the American people, Rep Rahm Emanuel expressed his disappointment that:

...an otherwise strong Free Trade Agreement has been tainted by provisions designed to protect a captive market for the prescription drug industry in this country...Eli Lilly, Schering-Plough, PhRMA were all on the advisory board to the USTR when it came to negotiating this trade deal, and we are setting a precedent, forcing Americans again to continue to pay the highest pharmaceutical prices than anywhere in the world when we could have provided Americans the chance of a free trade agreement where we reopen markets, bring in competition, lower the prices around the world.⁴

Restructuring of the trade advisory committees in August, 2004, did not address this problem. There continued to be strong representation in the advisory committee structure from the industries with a direct financial stake in trade, including pharmaceuticals and tobacco.

An analysis by CPATH in 2005 found that the number of representatives from the health-related pharmaceutical, tobacco, alcohol, processed food, and health services and products industries totaled 42 representatives on 25 committees. The pharmaceutical industry had 20 representatives, and the tobacco industry had 7. The Chair of the Advisory Committee on Consumer Goods (ITAC 4) was from the corporate tobacco giant Altria. The Chair of the Services and Finance Industry advisory committee (ITAC 10) was and today still is the president of the U.S. Coalition of Service Industries, the largest lobbying group in the U.S. of services companies, including health services.⁵

The extent of the representation from the public health community in 2005 persisted: Zero.

In June of 2006, 6 key Senators and 9 Congressional Representatives, including Senator Kennedy, and Representatives Stark, McDermott, and Emanuel, urged the USTR to appoint a public health representative to the top Advisory Committee for Trade Policy and Negotiations, and to create a new Tier 2 advisory committee, specifically addressing public health, to provide advice, technical information, and guidance on policies affecting health care, global health, environmental health, and other important issues.⁶

The absence of and continued need for public health representatives were chronicled in the September 2007 GAO Report entitled, "Intellectual Property – U.S. Trade Policy Guidance on WTO Declaration on Access to Medicines May Need Clarification."⁷ The report found that input

⁴ Congressional Record, July 14, 2004 House of Representatives debate on the U.S.-Australia Free Trade Agreement, H.R. 4759. <http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi>, H5708.

⁵ ITAC 10 Membership, <http://www.ita.doc.gov/itac/committees/services.asp>, accessed 7-15-09.

⁶ Letter to USTR Susan Schwab, June 14, 2006, from U.S. Congress, http://www.cpath.org/sitebuildercontent/sitebuilderfiles/letter_ustrschwab_14june06.pdf.

related to public health into U.S. trade negotiations had remained limited since Congress enacted the Trade Promotion Authority (TPA) in 2002. Two individuals associated with public health were appointed to two advisory committees that address pharmaceuticals, otherwise composed of 20 and 33 private sector representatives from the pharmaceutical and other industries. The report found little evidence that “USTR discussed the concerns submitted about the public health impact of FTAs with U.S. health agencies or other members of the public health community,”(p.55) and that there was little evidence that HHS or other U.S. agencies have determined whether FTAs affect public health, either positively or negatively.(p.52) As a possible explanation for the lack of consideration of public health concerns, the report notes that input USTR receives through informal channels (outside the trade advisory system) “may lack the weight of formal private sector input on public health issues in trade agreements.”(p.57)

U.S. Trade Advisory Committees in 2009 - Increased Domination by Corporate Health Interests

In May, 2009, CPATH’s updated analysis of the composition of U.S. trade advisory committees found that over the past five years, health-related industries have significantly increased their representation on advisory committees. The only decline is in tobacco industry representation. The number of representatives from health-related industries increased to 65, from 42 in 2005, and the breadth of representation from health-related industry representatives increased from a presence on 25 committees to a presence on 31 committees. The pharmaceutical industry increased their representatives from 20 to 27. The change is illustrated in the table below.

Industry Represented	2005	2005	2009	2009
	No. of Advisory Committees	No. of Industry Representatives	No. of Advisory Committees	No. of Industry Representatives
Pharma	6	20	7	27
Tobacco	2	7	3	6
Alcohol	4	6	5	8
Food	13	4	13	7
Health Services, Products, Insurance	2	5	5	17
TOTAL:	27	42	33	65

The U.S. Trade Representative and Congress are calling for formal representation by public health representatives on U.S. trade advisory committees. An assessment of previously negotiated Free Trade Agreements (FTAs) below demonstrates the urgency of such action, in order to provide advice on the United States-Trans-Pacific Partnership Trade Agreement.

⁷ GAO-07-1198, Intellectual Property, <http://www.gao.gov/new.items/d071198.pdf>, p. 5.

II. Assessment of Australia, Chile, Peru, and Singapore Free Trade Agreements

1. Intellectual Property Rights and Access to Affordable Medicines -

High prices restrict access to prescription drugs in lower income countries and also in developed countries which lack regulatory mechanisms to address drug pricing, such as the United States. Few useful innovative drugs are being developed, despite substantial revenue from drug sales. There is insufficient research into therapies for conditions prevalent in low-income countries.

Trade agreements negotiated by the United States have enforced, extended, and progressively strengthened intellectual property (IP) rights internationally, such as patents, data exclusivity and linkage, that offer monopoly marketing rights to pharmaceutical companies which therefore exert tremendous influence over prices. The World Trade Organization's (WTO) Doha Declaration on Public Health notes that intellectual property protection is important for the development of new medicines. But it also states that IP rules "should not prevent [countries] from taking measures to protect public health." It reaffirms the right of WTO countries to use the flexibilities in TRIPS (Agreement on Trade Related Aspects of Intellectual Property Rights), including their right to issue compulsory licenses to produce brand name or generic equivalents of originator companies' drugs, and parallel importation. Respect for the Doha Declaration, and a fair balance of rights, was also stated as a Congressional objective in the Trade Act of 2002.

These rights were eroded in a number of U.S. bilateral and regional agreements with Jordan, Chile, Singapore, Morocco, Australia and Central America. Civil society organizations in the U.S. and in partner nations raised concerns, which frequently delayed negotiations. In May, 2007, with leadership by the Trade Subcommittee of the Ways and Means Committee, Congress took action to limit negotiations with lower income countries on "TRIPS-Plus" IP rules.

Singapore and Chile FTAs – Setting Precedent for Strong Intellectual Property Rights for Pharmaceutical Companies

The Singapore and Chile Free Trade Agreements were the first to be negotiated under the Trade Act of 2002. These agreements set precedent for future FTAs, including concerning intellectual property rights related to pharmaceuticals.

The Singapore and Chile Free Trade Agreements substantively failed to achieve the overall and principal negotiating objectives set forth in the Trade Act of 2002 in key areas related to protecting the public's health, including the negotiating objective which calls for respect of the Declaration on the TRIPS Agreement and Public Health, adopted by the WTO Ministerial held in Doha on November 14, 2001.⁸

- Impede access to life-saving medicines.
 - Patents can be extended beyond the 20-year term required by TRIPS. (Singapore)
 - Requires a 5-year waiting period before governments can provide generic producers access to the test data produced by pharmaceutical companies, delaying affordable access to medicines. (Singapore)

⁸ Trade Act 2002, (Sec. 2102(b)(4)(c)).

- Restrictions on how governments provide marketing approval and sanitary permits for medicines. Pharmaceutical companies could block production of generic medicines.

Australia FTA – Conflicting with Efforts to Make Prescription Drugs Affordable

In July 2004, CPATH’s analysis alerted Congress and the public that the U.S.-Australia Free Trade Agreement (FTA) would conflict with efforts to make prescription drugs more affordable for uninsured Americans and other vulnerable populations.

At the time, many members of Congress and the public had expressed interest in reimportation as a partial solution to unaffordable drug prices in the U.S. As CPATH reported in testimony to the House of Representatives on July 16, Chapter 17.9.4 of the Australia Free Trade Agreement on parallel importation would effectively block reimportation of lower priced drugs into the U.S from Australia. Prior to that testimony, the US Trade Representative maintained that provisions on reimportation had been removed from the Agreement.

Chapter 17.9.4 states:

Each Party shall provide that the exclusive right of the patent owner to prevent importation of a patented product, or a product that results from a patented process, without the consent of the patent owner shall not be limited by the sale or distribution of that product outside its territory, at least where the patentee has placed restrictions on importation by contract or other means.

In contrast to other language in the Agreement, which sets obligations the Parties (referring to countries) have with respect to each other, this section refers only to what each Party must do, with respect to patent holders. These patent holders include drug companies, as well as other kinds of companies. Because of the way it is worded, this provision arguably requires the U.S. to prohibit reimportation of drugs from any other country, if drug patent holders require it so do so.

In 2004, the Office of the U.S. Trade Representative (USTR) acknowledged that the Agreement would conflict with pending Congressional legislation to authorize reimportation of less expensive medications. Responding to questions from Rep. Sander Levin at a Ways and Means hearing on June 23, 2004 John Veroneau, general counsel for the Office of the USTR, confirmed that new legislation on drug reimportation “could give rise to an inconsistency between U.S. law and a commitment under this trade agreement.”

Under other provisions of the Australia FTA:

- **Government Procurement provisions make it possible for drug companies to challenge drug listing and pricing decisions by the Department of Veterans Affairs. These challenges could lead to higher drug prices for veterans’ medications.**

The VA system effectively achieves very low prices for medicines. In a written response to questions posed by the U.S. Senate Finance Committee on April 27, 2004, the Deputy U.S. Trade Representative confirmed that the U.S.-Australia Free Trade Agreement did apply to the VA, the Department of Defense, and other federal agencies that procure pharmaceuticals. These agencies are covered by Chapter 15 of the Agreement, on Government Procurement, which includes provisions on transparency, technical specifications, and independent review of agency procurement decisions.

(The USTR’s statement accurately reported that “Procurement of pharmaceutical products by the Veterans Administration (VA) and the Department of Defense (DoD) is excluded from the Pharmaceutical Annex of the agreement.” This does not mean, however, that VA pharmaceutical procurement is exempt from the Agreement. While it is not covered in the Pharmaceutical Annex, it is covered by Chapter 15 of the Agreement, which addresses Government Procurement.)

- **New provisions in the Australia FTA provided greater leverage to the pharmaceutical industry to influence drug listing and pricing decisions.**

Under Article 15.11 “suppliers” have the right to challenge VA procurement decisions, including listing and pricing pharmaceuticals. Suppliers are defined as businesses, according to the USTR.

15.11.1: “In the event of a complaint **by a supplier** of a Party that there has been a breach of the other Party’s measures...the Party of the procuring entity shall encourage **the supplier** to seek resolution of **its complaint** in consultation with the procuring entity.”

15.11.2: “Each Party shall maintain at least one impartial administrative or judicial authority that is independent of its procuring entities to receive and review **challenges that suppliers submit**, in accordance with the Party’s law, relating to a covered procurement.”

- Other rules in the Australia FTA have made it possible to delay the entry of competing generic drug producers into the market. Health experts in Australia raised concerns that several provisions of the Agreement would raise drug prices there. These intellectual property rights provisions were contrary to U.S. trade policy, which generally seeks to lower prices internationally through market competition.

2. Tobacco Control and Protection of Public Health

Globally, tobacco use is expected to kill over 10 million people by 2030. Seventy per cent of the deaths are expected to occur in low and middle income nations. Worldwide, tobacco use is more prevalent among the poor, the uneducated, and those least informed about the effects of tobacco use.⁹

According to the Pan American Health Organization: “Transnational tobacco companies...have been among the strongest proponents of tariff reduction and open markets. Trade openness is linked to tobacco consumption.”¹⁰ Liberalization of trade in tobacco opens countries to competition from lower priced foreign tobacco products, leading to lower prices in the importing country. Liberalization, and lower prices, are therefore associated with greater tobacco use.

A nation that imposes restrictions on tobacco imports, or on the distribution, labeling or advertising of cigarettes, may be challenged to prove that these restrictions are "necessary" for tobacco control, and are less restrictive on trade than alternative health protections—for example,

⁹ E R Shaffer, JE Brenner, and T P Houston. Research Paper: International trade agreements: a threat to tobacco control policy. Tobacco Control 2005;14(Supplement 2).

¹⁰ D. Woodward, N. Drager, R. Beaglehole, D. Lipson. Globalization, global public goods, and health. In: Trade in Health Services: Global, Regional and Country Perspectives. N. Drager and C. Vieira, Eds. Washington, DC: PAHO, 2002. pp 6-7.

consumer health warnings. The health protective alternatives can be hypothetical, and need not be demonstrably effective or politically feasible.

The Doggett Amendment to the Foreign Service Act, passed by Congress in 1997, banned the use of government monies from the Commerce, Justice, and State Departments to promote the sale or export of tobacco overseas or to seek the removal of any nondiscriminatory foreign-country restrictions on tobacco marketing. However, it is subject to annual renewal, and compliance is up to the USTR and other Agencies. Unfortunately, the Doggett Amendment has not been honored since 2001. The U.S. has negotiated eliminating tariffs on tobacco products as well as leaf in bilateral and regional agreements, including the U.S. Singapore Agreement and CAFTA. It is perhaps time for a change.

There is a single public health representative on one of the committees concerned with tobacco leaf, compared with **6 tobacco industry representatives on 3 different trade advisory committees.**

According to the Pan American Health Organization: “Transnational tobacco companies...have been among the strongest proponents of tariff reduction and open markets. Trade openness is linked to tobacco consumption.”¹¹

Singapore and Chile FTAs – Reducing Tariffs on Tobacco and Tobacco Products

Tariffs on tobacco are lowered - Tariffs on tobacco and tobacco products are to be progressively reduced in the Singapore FTA (Annex 2B-Schedule-83-85). A phase-out of tariffs on tobacco products was included in the final U.S.-Chile Free Trade Agreement (FTA).

Peru FTA – Eliminating Tariffs on Tobacco Products

Tobacco use is the leading preventable cause of death and disease in the world. In the Americas, the number and percent of smokers has tripled in low-income countries since 1970. The Peru Agreement will interfere with public health efforts to reduce the five million tobacco-related deaths a year. It **eliminates tariffs on tobacco products.** The Investment, Services and Intellectual Property chapters continue to permit challenges to tobacco control measures as nontariff barriers to trade.

Peru FTA Problem 1, Tariff Provisions: **The agreement reduces to zero a number of existing tariffs on tobacco products.**

Peru FTA Problem 2, Nontariff Provisions: Unless explicitly excluded, tobacco products are subject to all trade rules, which have implications for tobacco control measures on distribution of tobacco products, trademarks, and advertising. Provisions of the Intellectual Property article on advertising, trademarks and labeling, Services rules on product regulation and distribution, and rules on market access, and national treatment, could all interfere with tobacco control measures. Tobacco control measures have been subject to trade challenges in the past, under the Investment provisions, and continue to be vulnerable in the Peru agreement, since they are not explicitly excluded.

Peru Problem 3: Although tobacco products may be explicitly excluded in the future, dispute panels could construe them as subject to trade rules due to unforeseen circumstances. For example, although

¹¹ D. Woodward, N. Drager, R. Beaglehole, D. Lipson. Trade in Health Services: Global, Regional and Country Perspectives.

the US did not make a commitment on gambling under GATS, a WTO trade panel found that it was covered as a recreational service.

3. Trade in Services and the Nation's Health

Defining vital human services such as health care and water as tradable commodities is relatively new, and in conflict with an array of international accords that construe access to health care and water as basic public health and rights issues, as well as being essential to sustainable economic development.

An independent review of the effects of trade in health services points out significant drawbacks for population health and equity.¹² A recent WHO/WTO report concludes that trade in health services cannot improve equity unless “regulatory systems are in place and the capacity to implement them is strengthened.”¹³

A range of vital human services such as water supply, health care, and education, as well as financial and commercial services, have been included in trade negotiations, and in some trade disputes. Antigua's trade dispute challenging the U.S. regulations on internet gambling came as a surprise to some U.S. negotiators, who stated they had not intended to include this activity in the commitment on recreation. A similar misunderstanding contributed to invalidating a Mexican surcharge on telecommunications under the WTO's General Agreement on Trade in Services.

There are inevitably complex issues regarding the relationship of important public health protections, the concerns of domestic and foreign service suppliers, and the appropriate national and international locus for decision-making on a number of issues.

Singapore and Chile FTAs – Impact on Health Care, Water, and Vital Human Services

The Singapore and Chile Free Trade Agreements set precedent for future FTAs, including application to and impact on health care, water, and other vital human services.

- The Singapore FTA would facilitate further privatization and deregulation of vital human services, including health care and water. It proposes new powers for trade tribunals to override public protections if they conflict with the interests of private corporations, and thereby undermines the ability of public bodies to safeguard population health. Provisions assume that a range of public protections may be barriers to trade, and therefore warrant challenge. From a public health perspective, the evidence suggests the reverse conclusion: that privatization and deregulation pose barriers to population health, and therefore call for closer scrutiny. While some

¹² R. Chanda. Trade in health services. Working Paper No. 63. Commission on Macroeconomics and Health, World Health Organization. June 2001.

¹³ http://www.who.int/media/homepage/who_wto_e.pdf WTO Agreements and Public Health – a joint study by the WHO and the WTO secretariat.

services and some professions are exempted from coverage by some trade rules, these exemptions are too narrow to assure full protection.

Health Care Professionals: Migration and Standards

Singapore exempts nurses and midwives, physicians, pharmacists and contact lens practitioners from local presence and national treatment rules, meaning that it can require these professionals to be resident in and registered in Singapore. Only physicians and pharmacists, however, are exempt from the market access rules (number and supply of services).

Chile exempts nurses and physiotherapists from market access rules (number and supply of services) but not from other rules.

The US lists no specific exclusions for health care professionals. The agreements call for professional bodies generally to develop mutually acceptable standards for training, licensing and recognition, and where there is agreement, encourages countries to develop procedures for temporary licensing.

Water and Sanitation

The World Health Organization has declared that: “**No single intervention has greater overall impact upon national development and public health than does the provision of safe drinking water and proper sanitation.**”¹⁴ International accords regard water as a public good, and increasing access to water as a high priority. Water is considered a good under NAFTA, while water collection and delivery are considered services. Water privatization has been adopted in parts of the U.S., a relatively new phenomenon, and promoted in the developing world by international financial institutions.

- The Singapore FTA applies to vital human services including health care and water. Domestic regulations in these areas, including those proven effective in advancing and protecting public health, could be challenged before international trade tribunals as burdensome barriers to trade.

Singapore exempts sewage treatment and potable water from most rules (National Treatment, Market Access, etc.) but not from Domestic Regulation (standards can be no more burdensome than necessary).

Chile exempts drinking water and waste water from the National Treatment and Most-Favored Nation rules, but not from Market Access, and permits such services to be supplied by corporations established in accordance with Chilean law, which could be foreign.

The US lists no exemptions.

- Both Singapore and Chile FTAs grant foreign private investors greater rights than US investors. Under NAFTA, similar provisions have led to lawsuits by private companies that overturned important health and environmental protections. This contradicts the negotiating objectives of the Trade Act of 2002.

¹⁴ World Health Organization. Water and Sanitation. Fact Sheet No. 112, November 1996.
www.who.int/inffs/en/fact.1112.html,

PERU FTA – Applies to Vital Human Services, e.g., Health Care, Water Supply, Food Safety

Problems with the Peru FTA:

Problem 1.1: The Agreement applies trade rules to vital human services such as health care, water supply and sanitation, food safety and supply, and education, including licensing and cross-border movement of personnel in these fields. Universal access to these services is a human right and a key to economic development. Assuring access, quality and affordability must take priority over encouraging market competition and protecting corporate rights.

Problem 1.2: Trade rules also limit governments’ ability to assure that these services are regulated in a manner that promotes and protects the public’s health. Article 11 on Services can challenge government regulations on services that are necessary to promote and protect public health.

Article 11.7 on Domestic Regulations requires that in order to ensure that “measures relating to qualification requirements and procedures, technical standards, and licensing requirements do not constitute unnecessary barriers to trade in services, each Party shall endeavor to ensure, as appropriate for individual sectors, that such measures are:

- (a) based on **objective** and transparent criteria, such as competence and the ability to supply the service;
- (b) not **more burdensome than necessary** to ensure the quality of the service; and
- (c) in the case of licensing procedures, not in themselves a restriction on the supply of the service.”

A necessity test would be determined by trade authorities, not by public health officials. It could be used to challenge a range of important public health regulations.

In its 2006 report on the Peru FTA, the Intergovernmental Policy Advisory Committee on Trade (IGPAC) noted that: “To raise objectivity [in regulatory decision-making] to the level of an international obligation ... undermines the ability of domestic regulators to deal with the inherent complexity of service industries. An international objectivity test moves in the direction of standardized and technocratic regulation and away from regulation in the public interest by legislatures and utility commissions that are accountable for balancing diverse public interests.”¹⁵

Problem 2.1: The Services rules can compromise governments’ ability to provide vital human services in the public sector. Trade rules on market access, national treatment, professional services, domestic regulation, and government procurement limit governments’ ability to assure that they can finance and provide vital human services through the public sector currently or in the future should they choose to do so.

Provisions that could exclude some public services are too weak and general to provide ironclad exemptions. Article 11.1.6 excludes “services supplied in the exercise of governmental authority in a Party’s territory,” meaning “any service which is supplied neither on a commercial basis, nor in

¹⁵ http://ustraderep.gov/assets/Trade_Agreements/Bilateral/Peru_TPA/Reports/asset_upload_file473_8977.pdf

competition with one or more service suppliers.” Health care programs that exclude some benefits, and nurse registries that serve public hospitals, could fail these criteria.

Social services: In Annex II: Non-Conforming Measures for Services and Investment, “the United States reserves the right to adopt or maintain any measure with respect to the provision of law enforcement and correctional services, and the following services **to the extent they are social services established or maintained for a public purpose:** income security or insurance, social security or insurance, social welfare, public education, public training, health, and child care.”

The definitions used to determine whether these important services are truly social services, and established or maintained for a public purpose, are unclear. Many such services involve both public and private payors, purchasers, and suppliers.

Problem 2.2: Social services are exempted from some trade rules, but not from market access (restricting the number or type of providers for a specific good or service, such as the number of liquor distributors on a block) and domestic regulation (regulations can’t be more burdensome than necessary to trade).

Peru exempts measures on potable water and sewage services from market access and local presence rules, but not from other rules

Problem 2.3: The list of social services does not include water supply and sanitation as exempted services.

Problem 3: A negative list is used to determine which services will be covered by which trade rules. This method assumes that all services are covered by all trade rules, unless they are explicitly stated to be exempt.

III. Recommendations

We want to ensure that the injuries to public health imposed by existing FTAs are not perpetuated by this new round of trade negotiations.

CPATH therefore recommends robust Public Health Objectives as well as specific recommendations for the Trans-Pacific Partnership agreement negotiations that will safeguard the health of Americans and our trading partners, and **promote economically and socially just, democratically controlled, and environmentally sustainable outcomes.**

In order to address public health concerns, CPATH recommends the following:

Public Health Objectives for the United States-Trans-Pacific Partnership Trade Agreement

1. **To assure democratic participation by public health and transparency in trade policy** by:
 - a. Appointing to all three tiers of trade advisory committees representatives of organizations that work to assure equitable access to affordable health-related services and products, and promote the health of individuals, communities and populations, who

- can provide formal advice to USTR from the public health and health care community to USTR.
- b. Opening all proceedings and documents of the trade advisory committees regarding the TPP to the public, and
 - c. USTR consulting with all relevant committees of the House and Senate in the development, negotiation, implementation, and administration of trade and negotiating objectives and positions for the TPP.
2. **To develop mutually beneficial trade relationships with TPP partners that create sustainable economic development** for the U.S. and our trade partners in an increasingly interdependent world.
 3. **To recognize the legitimate exercise of national, regional and local government sovereignty to protect population health**, and to ensure that countries do not weaken or reduce, as an encouragement for trade, sound policies that contribute to health and well being, including laws on public health, the environment and labor.
 4. **To exclude tariff and nontariff provisions in the TPP that address vital human services** such as health care, water supply and sanitation, food safety and supply, and education, including licensing and cross-border movement of personnel in these fields.
 5. **To exclude tobacco and tobacco products**, which are lethal, and for which the public health goal is to reduce consumption, from tariff and nontariff provisions of the TPP, including advertising, labeling, product regulation and distribution.
 6. **To exclude alcohol products**, which present serious hazards to public health. Policies designed to reduce the harm caused by alcohol products should not be subject to compromise in exchange for other trade benefits.
 7. **To eliminate intellectual property provisions related to pharmaceuticals from TPP negotiations**, as these are more appropriately addressed in multilateral fora, **and promote trade provisions which enable countries to exercise all flexibilities provided by the Doha Declaration on Public Health**, including issuing compulsory licenses for patented pharmaceuticals, parallel importation, and other measures that address high prices and promote access to affordable medicines.

Specific Recommendations for Trade Negotiating Objectives and Process for TPP:

1. **Democratic Participation and Transparency**
 - Improve and deepen consultations with public health representatives.
 - **Open all proceedings** and documents of trade advisory committees to the public.
 - **Publish** all proceedings of the meetings.
2. **Develop mutually beneficial trade relationships that create sustainable economic development** for the U.S. and our trade partners in an increasingly interdependent world.
 - Implement trade policies and provisions that facilitate sustainable development, including **public investment in infrastructure and human resources**.
 - Examine **models to reduce economic and social asymmetries and inequalities**, including

the EU and MERCOSUR.

- **Assess the impact of the TPP on public health.**
- **Assess the comparative costs and benefits** of the TPP to the federal budget and US economy, particularly in terms of employment creation/retention and trade value, of the allocation of resources and trade protections to agricultural commodities, technology research and development, industrial goods, manufactured products, and services sectors, including international trade and investment data at the state level on services and merchandise imports and exports, and on international investment.
- Develop an economic program that **supports and trains workers** for the emerging high-tech economy, with strong social supports for valued community members who do not work including children, the elderly, caregivers, and people with employment limitations.

3. Recognize the legitimate exercise of national, regional, state and local government sovereignty to promote and protect population health, and to ensure that countries do not

weaken or reduce, as an encouragement for trade, sound policies that contribute to health and well being, including laws on public health, the environment and labor.

- The TPP should be negotiated, implemented, and interpreted to **safeguard existing state and local level regulatory, tax, and economic development policies, and to support the social, economic, and environmental values that those policies promote.**
- **Eliminate “investor-state” provisions** that give foreign corporations the right to file trade disputes based on measures of state and local governments, and that give greater rights to foreign investors than to domestic ones.
- The TPP should state that statutes and regulations of states and local governments are afforded the same protection against preemption as those of the federal government, i.e. that nothing in the Agreement shall preempt any state or local law.
- Codify in the Agreement that:
As a matter of general international law, a non-discriminatory regulation for a public purpose which affects a foreign investor or investment is not deemed expropriatory and compensable.
- Maintain the principle that the United States may not require states to alter their regulatory regimes in areas over which they hold constitutional authority. The U.S. must obtain approval from the legislature and executive of the implicated state or locality before a state or locality is bound by any trade provision or a rule, regulation, or statute is listed in – or otherwise implicated by – a trade agreement, offer or other binding commitment.
- **Exempt state laws on government procurement for health care services from trade rules.**

4. Services

- Specifically **exclude** from trade agreements **vital human services** such as health care, water supply and sanitation, food safety and supply, and education, including licensing and cross-border movement of personnel in these fields. **Eliminate any requirement that they be established or maintained for a public purpose.**
- **Eliminate any requirements for a necessity test and an objectivity test in regulatory decision-making.** Trade tribunals should not be authorized to determine whether measures regarding essential services are objectively determined, or necessary to ensure the quality of services, public health and safety, environmental protection, and other important policy objectives.
- Trade commitments for the TPP should be derived via a process based upon “**positive lists**,”

that require the affirmative, informed consent from affected national, state and local entities, in consultation with public health representatives, to list each service.

5. Exclude tobacco products, which are lethal, and for which the public health goal is to reduce consumption, from tariff and nontariff provisions of trade agreements, including advertising, labeling, product regulation and distribution.

- **Tariff and Nontariff Provisions:**

Exclude tobacco products from all trade rules and in each relevant Schedule and Annex, including but not limited to Market Access, Most Favored Nation, National Treatment, Services, Intellectual Property, and tariff reduction schedules.

- **Negotiate to add** the following:

“Notwithstanding any language to the contrary, nothing in this agreement shall block, impede, restrict, or modify the ability of any party to take or maintain any action, relating to manufactured tobacco products that is intended or expected, according to the party, to prevent or reduce tobacco use or its harms and costs or that is reasonably likely to prevent or reduce tobacco use or its harms, including tariffs and restrictions on the marketing of tobacco or tobacco products.”

- **Negotiate to add** the following: ‘Provisions of the Framework Convention on Tobacco Control shall govern, in the event of any conflict with this Agreement.’”

6. Alcohol Beverage Control

- **Negotiate to add** the following:

“Notwithstanding any language to the contrary, nothing in this agreement shall block, impede, restrict, or modify the ability of any party to take or maintain any action, relating to alcohol beverages that is intended or expected, according to the party, to prevent or to reduce harm to the public’s health related to alcohol beverage use or that is reasonably likely to prevent or reduce alcohol beverage use or its harms, including tariffs and restrictions on the marketing of alcohol beverages. “

- **Encourage** the World Health Organization to develop a legally binding international convention on alcohol beverages.

7. Intellectual Property and Access to Medicines - Eliminate intellectual property provisions related to pharmaceuticals from bilateral and regional negotiations, as these are more appropriately addressed in multilateral fora, **and promote trade provisions which enable countries to exercise all flexibilities provided by the Doha Declaration on Public Health**, including issuing compulsory licenses for patented pharmaceuticals, parallel importation, and other measures that address high prices and promote access to affordable medicines.

- **Exclude all TRIPS-plus provisions** from the TPP agreement.

- **Provide technical, political, and economic support to trading partners to enact and enforce TRIPS public health safeguards**, as reaffirmed by the Doha Declaration on TRIPS and Public Health.