

Health risks of including alcohol and tobacco in PICTA free trade

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Abstract

In April 2005 Pacific Forum leaders will decide whether to include alcohol and tobacco in the Pacific Island Countries Trade Agreement (PICTA). This article presents arguments for keeping alcohol out of regional free trade agreements. Inclusion will allow regional rationalisation of production, increased alcohol availability, competition and marketing, and lower prices. These trade goals are inappropriate for alcohol and tobacco.

Pacific public health organisations are concerned that official advice has focused on fiscal impacts, not health and social impacts. The World Health Organization has identified alcohol as the leading factor in injury and disease for low-mortality developing countries. Effective policies to reduce alcohol related harm include restrictions on availability, as well as excise taxes affecting price. Under trade agreements elsewhere, national alcohol policies have been challenged as 'non-tariff barriers to trade'. Hazardous drinking is of increasingly concern in the Pacific and decisions about alcohol should not reflect commercial interests.

Introduction

Pacific Forum leaders are scheduled to consider, by April 2005, whether alcohol and tobacco should be included in the Pacific Island Countries Trade Agreement (PICTA), allowing regional free trade. Pacific Islands public health people meeting in Auckland in September 2004 were shocked to learn, however, that advice given to Forum Trade Ministers had not included the social and health impacts of alcohol and tobacco.

A meeting participant had obtained an unpublished study commissioned by Pacific Forum Secretariat in 2003,¹ together with an issues paper summarising its contents for Ministers. The terms of reference for the study did not include health effects of free trade in these products; just the impacts of inclusion on local economies and government revenues. The Narsey report recommended that both tobacco and alcohol should be included in PICTA, and that tariff protections should be converted into excise taxes on both imported and domestic products so as to protect revenues and price levels. Options included putting alcohol and tobacco on an 'excepted' or 'negative' list – which means merely a slower time frame for tariff reduction.

The Auckland meeting at which this was discussed had been convened by the New Zealand Ministry of Health and Professor Sally Casswell, chair of the World Health Organization's Advisory Committee on Alcohol Policy. Its purpose was to encourage networking in the Pacific region on alcohol issues and the development of effective policies. Some participants were on their way to Noumea for the first ever meeting between WHO and the Secretariat of the Pacific Community (SPC) on Alcohol and Health in the Pacific. They raised their concern about including alcohol and tobacco in Pacific free trade. In late 2004, the SPC commissioned its own health impacts report on the inclusion of tobacco and alcohol in PICTA. This reviewed the international evidence as well as the data available from Pacific Islands countries and recommended that alcohol and tobacco continue to be excluded from PICTA on public health grounds.²

Alcohol and tobacco are major contributors to the global burden of injury and disease. The rationale for free trade agreements is that competition increases product availability and range, and reduces prices to the consumer. These goals are inappropriate for products that result in considerable harm to health. The World Bank has noted that alcohol and tobacco are not suitable products for development investment, because of their well-known impacts on public health.³ Nor are they suitable products for Pacific free trade.

This article recommends strongly that alcohol and tobacco should continue to be totally excluded from PICTA negotiations. In regard to tobacco, health risks are well-known and the Framework

Convention on Tobacco Control provides guidance on appropriate policies. This article focuses on the case for excluding alcohol.

WHO alerts member countries to alcohol risks

There is an inherent tension between trade agreements that facilitate the growth and globalisation of the alcohol industry and international public health efforts to reduce alcohol related harm.

In May 2004, the World Health Assembly urged member countries to recognise alcohol as a risk factor for public health and to develop strategies to reduce its adverse physical, mental and social consequences.⁴ In December 2004, the World Health Organization reported in strong terms on the public health problems caused by alcohol and proposed policy strategies to reduce the alcohol related burden of harm.⁵

The World Health Report 2002 identified alcohol as the fifth largest factor contributing to the global burden of injury and disease. The contribution of alcohol is almost as high as that of tobacco (4.0 cf. 4.1) because, although smoking related disease incurs higher direct health costs, alcohol related injuries and deaths occur at younger ages, meaning more disability adjusted life years lost. In developed countries, alcohol is the third largest risk factor and accounts for 9.2 percent of the burden of injury and disease – net of alcohol's benefits in regard to the coronary heart disease prevalent in industrialised countries. Risks in developing countries were analysed by grouping countries with high and low overall mortality. In developing countries with low mortality – and the Pacific Islands fit this description – alcohol contributed 6.2 percent of the burden. In these countries, alcohol consumption now contributes to disease, injury, disability and premature death more than any other risk factor.⁶

The WHO Secretariat notes that heavy episodic drinking, particularly among young people, is on the rise in many countries throughout the world.³ Hazardous patterns of drinking are common in the Pacific, although this may not be apparent from per capita statistics as many Pacific Islanders do not drink at all. Alcohol was introduced by Europeans in the 19th century and has only been produced in

commercial quantities since the 1950s.⁷ The inclusion of alcohol in PICTA will ensure the market grows.

Rationalisation of Pacific alcohol production

The Narsey report for the Pacific Forum provides a picture of current alcohol production in the region. There are large breweries in Papua New Guinea and Fiji, moderate sized ones in Samoa and the Solomon Islands and five micro-breweries – two in Fiji and one each in Palau, Cook Islands and Tonga. There are distilleries in Papua New Guinea and Fiji. Each is important to the local economy and to government revenue but are ‘local’ mainly in a geographical sense. Most ingredients and materials are imported, which means ‘rules of origin’ trade protections will seldom apply. Master brewers are mostly ‘ex-patriots’ – i.e., also imported – and both breweries and distilleries are part-owned and controlled by Australasian companies that, since the mid-1990s, are part of a global alcohol oligopoly.

The report notes that all plants are operating below capacity, usual two or three days a week. The Fiji and Papua New Guinea breweries are on ‘a completely different tier of productivity’ from older plants. Economies of scale could allow one firm to supply the entire PICTA market, meaning reduced share, closure and employment losses for others. The PACER agreement allows Australia and New Zealand join in PICTA free trade eight years after commencement.^{8,9} Narsey notes that most Pacific spirits production is ‘virtually certain not to survive’ the extension of PICTA to Australia and New Zealand.

What the inclusion of alcohol in PICTA would allow, then, is a two-stage rationalisation of alcohol production and market growth in the interests of producers, not public health. This view is supported by news that distillers from around the world have been lobbying the World Trade Organization for further liberalisation of ‘trade and services’ in alcohol. Among these was New Zealand’s Distilled Spirits Association (whose members include a branch of global spirits corporation Diageo) who consider that New Zealand’s exports of gin, vodka, liqueurs and alcopops to 30 countries, including the Pacific, are currently hobbled by excessive tariffs and trade barriers.¹⁰

Similar rationalisation has already occurred for tobacco. One company, British American Tobacco (BAT) owns and controls all cigarette and tobacco manufacture in Pacific Forum countries, using a small amount of local leaf. BAT says one of its metropolitan plants could supply the entire Pacific market with a day's production run.¹

Challenges on trade agreement compliance

In other regions, legal challenges on non-compliance with GATT, NAFTA, GATS or the European Union single market treaty have not been limited to tariff matters and equal treatment of imported and domestic products. National policies that reduce availability or competition between products have also been challenged.^{11,12,13} State-owned bottle store monopolies have been challenged in the USA and Canada, despite demonstrated public health benefits. The effect of EU trade agreements on cross-border availability and excise tax rates has resulting in cheaper alcohol and increased consumption. Policies restricting place of sale and advertising have been challenged as trade barriers because they differentiated, not between imported or domestic products, but between different alcoholic beverages – for example, Scandinavian policies favouring lower alcohol beer over high strength spirits. Following a court challenge, Sweden had to rewrite legislation to justify longstanding and publicly supported policy restricting alcohol advertising. Yet international research shows that regulations restricting availability and taxation affecting price are the most effective policy strategies for reducing alcohol related harm, and the 'precautionary principle' should be exercised in regulating alcohol advertising.¹⁴

At a 2004 European conference on alcohol policy, a researcher quoted the World Trade Organization saying that trade treaties have an increasingly wide scope of application and 'extend into areas never before recognised as trade policy'. They affect domestic regulation by limiting policies to what is 'necessary' to achieve goals and 'consistent' with trade treaty obligations. Putting alcohol on an 'exceptions' list cannot be relied on to protect alcohol policies, as exceptions

are interpreted narrowly in international law and because progressive liberalisation is expected in successive rounds of negotiations.⁸

Does this view apply to PICTA? The recommended options in the Narsey report are about how fast current tariff regulations on alcohol are to be removed – either under ‘rules of origin’ (if applicable), an ‘excepted’ list or a specially designed tariff reduction schedule. The focus is on protecting government revenues from alcohol, not on protecting effective and independent government health policies.

To ensure national alcohol policies are not challenged as ‘non-tariff barriers to trade’, it will be important that they are clearly based on research evidence (international or local) and worded in such a way as to invoke Article 16 of PICTA which states:

Provided that such measures are not used as a means of arbitrary or unjustifiable discrimination between the parties, or as a disguised restriction on trade between the parties, nothing in this Agreement shall prevent the adoption or enforcement by a party of measures:....

- (a) Necessary to protect public morals
- (b) Necessary to protection human, animal or plant life or health;...
- (f) Necessary for the prevention of disorder or crime....

The words ‘necessary’, ‘arbitrary or unjustifiable’ and ‘exception’ should be noted. PICTA puts Pacific governments on the back foot in protecting public health. It requires them to defend their policies or adopt only policies that are consistent with trade principles. Not even the Framework Convention on Tobacco Control confers the right to adopt measures inconsistent with obligations under trade agreements – even where this would seem necessary to achieve the goals of the Framework Convention.

Unless alcohol and tobacco can be totally excluded from trade treaties altogether, the interests of global industries can begin to shape or dictate the public health policies of sovereign nations.

Effective alcohol policies

At the meetings in Auckland and Noumea, Pacific public health people talked about intoxication and alcohol related harm on their home island. Many Pacific countries have not yet implemented effective alcohol policies, and a free trade agreement may make it more difficult for them to do so. Some smaller Islands do not have formal licensing systems to regulate bars, with takeaway alcohol sold only by government bond stores – a ‘monopoly’ that could be challenged. Few Pacific governments have policy on alcohol advertising and marketing, which can be expected to increase if the regional alcohol market consolidates into the hands of fewer, larger companies.

While many Pacific people do not drink alcohol, those who do often drink until intoxicated – for reasons of past limited availability, hospitality obligations or perhaps patterns of consumption related to the ceremonial drink kava.¹⁵ The likely effects of increased availability, low prices and more marketing can be learned from experiences in other developing countries such as Malaysia¹⁶ and also from Pacific communities in New Zealand.

New Zealand liberalised its alcohol policies over the 1990s, resulting in increased availability, competition and high profile marketing, with prices for takeaway alcohol held down against inflation despite tax increases. There is now considerable concern about increased binge drinking by teenagers, particularly those under the legal age of purchase. A series of surveys have shown a low but growing proportion of drinkers among Pacific New Zealanders, with high incidence of hazardous consumption.^{17,18} A recent health survey of schools showed that, although fewer Pacific adults drink, Pacific high school students are now as likely to drink, and to drink as heavily, as their Palangi peers.¹⁹

Alcohol problems tend to increase with development, notes a WHO publication *Alcohol in Developing Societies*,²⁰ and are most likely to do so where there are no effective policies in place. These are needed to respond to current trends in Pacific drinking, even if governments decide against including alcohol in regional trade agreements. WHO notes that alcohol related problems can be significantly lessened by ‘best practice’ policy strategies⁴ identified by a review of alcohol policy effectiveness in

developed countries.¹³ *Alcohol in Developing Societies* summarises the lessons from this review as follows:

- The politically easy strategies are often the least effective.
- Well-designed alcohol education is appropriate in schools but is unlikely by itself to reduce alcohol-related problems.
- Public information campaigns have symbolic value, but usually little practical effect.
- Treatment helps drinkers and their families, but is unlikely to reduce a society's alcohol-related problems.
- Measures that restrict and channel alcohol sales and drinking can be effective in reducing alcohol related problems, including harm to those around the drinker.
- Effective measures include taxation; licensing the sale of alcohol with restrictions on outlet numbers, times and conditions of sale; a minimum age of purchase; and drink-drive law enforcement.
- Government monopolies of part or all of the retail or wholesale markets can be an effective means of control.
- Limits on advertising and promotion are an important precaution, although effectiveness may be hard to demonstrate in the short term.

In its 2004 *Global Status Report: Alcohol Policy*,⁷ WHO recommended that each country develop an alcohol strategy using a mix of effective, culturally appropriate policies. To achieve health goals, all government policies need to be heading in the same direction. The report noted the difficulty of achieving this in the context of market globalization and world trade agreements.

Conclusion

Alcohol is no ordinary commodity. Like tobacco, it is a major contributor to the global burden of injury and disease. Increased consumption can have adverse impacts on health, individual lives, families and communities.

The decision that Pacific leaders face about whether to include alcohol and tobacco in PICTA free trade may be assisted by keeping in mind words from the European Health Ministers' Declaration at the end of the WHO conference on Young People and Alcohol in 2003:

“Public health policies concerning alcohol need to be formulated by public health interests, without interference from commercial interests.”

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