OPHA
Ontario Public Health Association
l'Association pour la santé publique de l'Ontario
Established/Établi 1949

The mission of OPHA is to provide leadership on issues affecting the public's health and to strengthen the impact of people who are active in public and community health throughout Ontario.

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Association of Ontario Health Centres

Association of Public Health Epidemiologists in Ontario

Association of Supervisors of Public Health Inspectors of Ontario

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Community Health Nurses' Initiatives Group (RNAO)

Health Promotion Ontario: Public Health

Ontario Association of Public Health Dentistry

Ontario Society of Nutrition Professionals in Public Health

Public Health Research, Education and Development (PHRED) Program

Charitable Registration Number 11924 8771 RR0001

November 28, 2006

The Honourable Susan C. Schwab
U.S. Trade Representative
600 17th Street NW
Washington, DC 20508

The Honourable Peter Mandelson
European Commissioner for Trade
200 rue de la Loi
B-1049 Brussels
Belgium

Dear Ambassador Schwab and Commissioner Mandelson,

Re: U.S./EU "plurilateral" GATS request on alcohol distribution services

Canada's Ontario Public Health Association (OPHA)[1] has been a voice for public health in the province of Ontario since 1949. The OPHA is a voluntary, charitable, non-profit association consisting of individuals and ten constituent societies. Its mission is to provide leadership on issues affecting the public's health and to strengthen the impact of people who are active in public health and community health. The OPHA's Alcohol Workgroup[2] advocates specifically for alcohol policy development.

We are writing to express our concern that the U.S. and European Union negotiating position involving beverage alcohol in WTO services negotiations could harm public health in many countries. In particular, the U.S. and EU are jointly sponsoring a "plurilateral" (or collective) request in Distribution Services in negotiations on the General Agreement on Trade in Services (GATS) which, if adopted, would obstruct governments' ability to implement policies that reduce the substantial harm caused by alcohol. We urge you to reconsider this request.

There is a growing recognition that alcohol, like tobacco, is a global health issue. While many of us derive pleasure from drinking alcoholic beverages, alcohol is not an ordinary commodity. It is a drug that is linked to more than 60 different medical conditions and imposes a heavy burden on public health.[3] According to research conducted for the World Health Organization (WHO), *world-wide, alcohol-related harm is nearly equal to that caused by tobacco, and far greater than for illicit drugs;*[4] 4.0% of the global burden of disease is attributable to alcohol, compared with 4.1% to tobacco and 4.4% to high blood pressure.[5] In countries with emerging economies like China, alcohol surpasses high blood pressure and tobacco as the most detrimental risk factor, accounting for 6.2% of that country's burden of disease.[6] In developed countries, alcohol is the most significant avoidable health risk for adolescents and young adults.[7] In the EU, alcohol ranks third of 26 risk factors for ill-health in the general population, behind only tobacco and high blood pressure,[8] with the burden of alcohol-related harms unevenly distributed throughout the region.[9] In the U.S., alcohol is "the third leading preventable cause of death… and is a factor in approximately 41% of all deaths from motor vehicle crashes."[10]

The prevalence and severity of global alcohol problems has stimulated extensive research on the efficacy of the various alcohol policies designed to address them.[11] This research has provided governments a description of the toolkit of available policy options that are demonstrably effective in reducing alcohol-related harm.[12] In general, public health is improved when governments regulate alcohol—a drug—more restrictively than ordinary products. At the population level, policies that reduce overall alcohol consumption—by increasing the price of alcohol and by restricting its physical availability—hold the most promise as effective interventions to promote health.

We are troubled that the approach the U.S. and EU are pursuing in GATS negotiations could undermine the most effective health-based approaches to alcohol regulation. In particular, the U.S. and the EU are pressuring other countries to make full national treatment and market access commitments "with no limitations" in Distribution Services, which generally includes alcohol.[13] This pressure, from two of the most powerful WTO members, makes it more difficult for recipient country governments to adopt the very policies that recent evidence shows to be among the most effective in reducing the serious harm caused by alcohol in society.

For example:

- *Maintaining a publicly owned monopoly on alcohol retail outlets* is one of the most important means of regulating alcohol to improve public health. Monopolies often restrict the physical availability of alcohol by limiting the number of retail outlets and their hours of sale. They also remove the private profit motive for increasing alcohol sales generally, and to young people and persons who are already intoxicated in particular.

Applying *GATS Market Access* rules according to the U.S.-EU request would conflict with this public health approach, constraining governments' regulatory ability, and subjecting important internal public health decisions involving alcohol to WTO oversight and control. Under these rules, the creation of a much-needed public alcohol monopoly with a strong public health mandate would require governments to negotiate "compensatory adjustment" with other governments whose suppliers could be affected, or face punitive trade sanctions.

- *Maintaining high alcohol taxes and prices* is one of the most effective and efficient ways for governments to reduce alcohol-related health problems. Alcohol taxes are easy to establish and enforce and generate significant revenues for governments. Most importantly, high alcohol prices usually result in people consuming less alcohol, which leads to fewer alcohol-related problems, including among heavy or problem drinkers.[14]

  Applying the *GATS National Treatment* rule according to the U.S.-EU request would interfere with flexible, health-based alcohol taxation policy. This rule requires that governments provide *foreign* services and investments the best treatment given to like *domestic* services and investments. Far tougher than generally realized, the rule prohibits even indirect, unintentional or incidental unfavourable treatment of foreign alcohol and requires government to ensure that foreigners have "equality of competitive opportunity" with domestic suppliers. This rule can conflict with governments' ability to establish a minimum ('floor') price designed to restrain alcohol consumption and harm. It can also conflict with governments' ability to tax beverages according to their alcohol content to encourage the consumption of beverages having a lower alcohol content. The national treatment rule could also conflict with governments' ability to tax imported 'alcopops' (flavoured alcoholic beverages that are particularly attractive to youth) at disproportionately high rates to delay the onset of drinking, or to reduce alcohol consumption among young people.

The current suspension of the WTO talks offers a vital opportunity for the U.S. and the EU to revisit their position. If negotiations resume and are concluded on the basis of the current U.S.-EU plurilateral request, serious harm to public health could result, especially in developing countries.

International trade treaties have been identified as one of a series of factors, characterized as a "perfect storm", which could increase alcohol availability, increase alcohol consumption, weaken alcohol control policies, and have grave public health consequences in developing countries.[15] Regrettably, rather than ameliorating this disturbing scenario, the U.S.-EU "plurilateral" GATS request threatens to exacerbate public health problems in developing countries by making it more difficult for governments to implement the most effective health-promoting alcohol regulation policies.

Health-based alcohol policies in developed countries could also be affected. The request specifies that demandeurs—which include the U.S., the 25 EU countries, and 8 other countries—are deemed to be recipients of the request they have made of others.[16] As a result, the U.S.-EU initiative intensifies pressure against alcohol control policies—including the monopoly status and effectiveness of public alcohol retailers—in both the United States and European Union.

Members of the Ontario Public Health Association Alcohol Workgroup were heartened in 2003 when Canadian negotiators indicated that Canada would not *make* alcohol-related commitments and would not *seek* alcohol-related commitments from other countries in the current round of GATS negotiations.[17] More recently, we were gratified to learn that Canada did not co-sponsor the aforementioned plurilateral request.

Alcohol is no ordinary commodity. We encourage you to take advantage of the current hiatus in WTO negotiations to ensure that GATS and other trade treaty negotiations do not undermine domestic health-based alcohol policies.[18] As a first step, we urge you to either withdraw your support for the plurilateral request on Distribution Services or specify that it does not apply to beverage alcohol distribution.

Respectfully,

Dr. Garry Aslanyan
President, Ontario Public Health Association

c.c.
Hon. Tony Clement, Minister of Health
Hon. David Emerson, Minister of Trade
Ruby Dhalla, MP, Liberal, Health
Dominic Leblanc, MP, Liberal, Trade
Christiane Gagnon, MP, Bloc, Santé
Serge Cardin, MP, Bloc, Commerce international
Penny Priddy, MP, NDP, Health
Peter Julian, MP, NDP, Trade
Hon. George Smitherman, Ontario Minister of Health
Hon. Jim Watson, Ontario Minister of Health Promotion
Hon. Sandra Pupatello, Ontario Minister of Trade
Elizabeth Witmer, MPP, PC, Health
Ted Chudleigh, MPP, PC, Trade
Shelley Martel, MPP, NDP, Health
Gilles Bisson, MPP, NDP, Trade

Canadian Public Health Association
American Public Health Association
European Public Health Association
Canadian Medical Association
American Medical Association
British Medical Association
European Medical Association
World Medical Association
World Health Organization

U.S. National Conference of State Legislatures
U.S. National Alcohol Beverage Control Association

[1] The website of the Ontario Public Health Association is found at: http://www.opha.on.ca/about/index.html .
[2] The website of the OPHA Alcohol Workgroup is found at: http://www.opha.on.ca/workgroups/alcohol.html
[3] World Health Organization (2002), *The World Health Report 2002, Reducing Risks, Promoting Healthy Life*, Geneva, Switzerland: World Health Organization, p. 66.
[4] The World Health Organization recently identified alcohol as one of the world's top ten health risks. World Health Organization (2002), *The World Health Report 2002, Reducing Risks, Promoting Healthy Life*, Geneva, Switzerland: World Health Organization. See p. 82, Figure 4.9: "Global distribution of burden of disease attributable to 20 leading selected risk factors."

Of the 26 risk factors examined in the WHO 2000 Global Burden of Disease study, alcohol ranks as fifth most detrimental, accounting for about the same amount of global burden of disease (4.0%) as fourth-ranked tobacco (4.1%).

World Health Organization (1999) *Global Status Report on Alcohol*. Geneva, Switzerland: World Health Organization.

See also:

Babor, T., Caetano, R., Casswell, S, Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Gruenewald, P., Hill, L., Holder, H., Homel, R., Osterberg, E., Rehm, J., Room, R. and Rossow, R. (2003) *No Ordinary Commodity: Alcohol and Public Policy*, Oxford: Oxford University Press.

[5] *No Ordinary Commodity: Alcohol and Public Policy*, *supra*, note 4, Sect. 4.3.6
[6] Ibid.
[7] Ibid.
[8] Anderson, P. and Baumberg, B. (2006) Alcohol in Europe: A Public Health Perspective, Report for the European Commission, London, Institute for Alcohol Studies, pp. 5 (Summary), 195 (Ch. 6). The report is available at: http://ec.europa.eu/health-eu/news_alcoholineurope_en.htm ; accessed Sept. 30, 2006.
[9] Tigerstedt, C., Karlsson, T., Makela, P., Osterberg, E., and Tuominen, I. (2006) Health in alcohol policies: the European Union and its Nordic Member States, in: Stahl, T., Wismar, M., Ollila, E., Lahtinen, E, and Leppo, K., eds. *Health in All Policies: prospects and potentials*, Helsinki, Finland: Ministry of Social Affairs and Health, pp. 119-121. (Available at: http://www.euro.who.int/document/E89260.pdf ; accessed Nov. 2, 2006.)
[10] U.S. National Center for Chronic Disease Prevention and Health Promotion, http://www.cdc.gov/HealthyYouth/alcoholdrug/index.htm , Accessed Sept. 30, 2006. As support for these claims, the CDC cites the following studies:

Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. *JAMA* 2004;291(10):1238-1245;

U.S. Department of Transportation. Fatality Analysis Reporting System (FARS) Web-based Encyclopedia. Accessed June 1, 2006.

[11] Babor, et al., *supra*, note 4.
[12] International researchers have identified the following as 'best practices' in the regulation of alcohol to improve public health: minimum legal purchase age; *government monopoly of retail sales*; restrictions on hours or days of sale; outlet density restrictions; alcohol taxes; sobriety check points; lowered blood alcohol content limits; administrative license suspension; graduated licensing for novice drivers; and brief interventions for hazardous drinkers. (Babor, T., et al. (2004) *Communicating About Alcohol: Educational and Regulatory Policies*, Bridging the Gap, European Alcohol Policy Conference, 16-19 June 2004, Warsaw, Poland, adapted from *Alcohol: No Ordinary Commodity - Research and Public Policy* (2003) Oxford: Oxford University Press, italics added for emphasis.)
[13] This proposal was meant to remain confidential, but was leaked to the public. It is posted at: http://www.tradeobservatory.org/library.cfm?refid=79991 ; accessed Sept 5, 2006.

This request does contemplate that some "flexibility" could be "considered", but only for "a limited number of … exceptions". The proposal thus forces informed recipient countries to expend scarce negotiating capital either to avoid making commitments in Distribution Services or to obtain a protective exception for alcohol for the commitments they make on an individual, country-by-country basis.

[14] *No Ordinary Commodity: Alcohol and Public Policy*, *supra*, note 4.
[15] Caetano, R. and Laranjeira, R. (2006) A 'perfect storm' in developing countries: economic growth and the alcohol industry, editorial, *Addiction*, 101, 149-152.

[16] In paragraph 2, the request states: “The aforementioned interested Members are also deemed to be recipients of this request.” (Cf. note 13).

[17] Canadian government trade officials assured the Ontario Public Health Association that Canada will not make any offers or requests on alcohol-related services in the current round of GATS negotiations. These promises were made in a June 12, 2003 conference call with OPHA representatives in response to a series of written questions submitted by the OPHA a year earlier. The OPHA had raised concerns after leaked GATS negotiating documents showed that European negotiators were pressuring Canada to make extensive commitments which would have adversely affected health-based alcohol policy in Ontario and elsewhere in Canada.

[18] The World Medical Association, the global representative body for physicians, has proposed a general ‘carve-out’ from trade treaties for alcohol. At its October 2005 annual assembly, physicians representing more than 40 countries emphasized the need to reduce the global impact of alcohol on health and society in part by shielding alcohol policy from trade treaty constraints. The WMA recommends that:

“[I]n order to protect current and future alcohol control measures, [National Medical Associations should] advocate for consideration of alcohol as an extra-ordinary commodity and that *measures affecting the supply, distribution, sale, advertising, promotion or investment in alcoholic beverages be excluded from international trade agreements*.”[18]

World Medical Association (2005) Statement on Reducing the Global Impact of Alcohol on Health and Society, SMAC/Alcohol/Oct2005/2, adopted at 171st WMA Council Session, WMA General Assembly, Santiago, Chile, on October 17, Para. 19, italics added for emphasis.