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Combined Submission to the Senate Foreign Affairs, Defence and Trade References Committee on:

The relevant issues involved in the negotiation of the General Agreement on Trade in Services (GATS) in the Doha Development round of the World Trade Organisation

&

The proposed Free Trade Agreement (FTA) between Australia and the United States

April 2003
Central Australian Aboriginal Congress

Introduction

For close to thirty years since its establishment in 1973, Congress has been a strong advocate for the rights and needs of the Aboriginal people in Central Australia. Congress is an organisation of Aboriginal people for Aboriginal people, controlled by Aboriginal people. Congress has supported the establishment of many of the other Aboriginal community-controlled health and other organisations within our region. Congress established a health service in 1975, and now runs a comprehensive primary health service that includes: a medical (clinic) service, community health programmes, a women's health service and birthing centre (the Congress Alukura), a dental clinic, a child care centre, an education and training branch for Aboriginal Health Workers, a social and emotional wellbeing centre, a youth outreach programme and a bush mobile medical service (servicing outstations within 150km of Alice Springs). Congress has an active public health section, dealing with Aboriginal health policy development and public health research, as well as providing an evaluation and strategic planning function for our programmes.

In November 2002 the Congress Cabinet (governing board) adopted the following social justice principles relevant to this submission:

> **Self-determination**. All Aboriginal peoples have the right to self-determination as Indigenous peoples. This right, recognised internationally, includes the right to determine the nature of our own organisation, formulate policy that affects us, and the implementation of programmes under Aboriginal control.
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> **Social justice and equity**. Current extreme world inequality and inequity is wrong and must be changed. Cabinet supports measures to reduce these inequalities based upon principles of fairness and non-exploitative relationships. Cabinet opposes discrimination that unfairly disadvantages people on the basis of race, gender, sexual preference or beliefs.
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> **Governments** have a responsibility to ensure that all citizens enjoy the same standards of access to services and must fund these services on a per capita basis, with loadings to address existing socio-economic inequalities, disadvantage, geographic isolation and costs peculiar to maximising community control of these services. Further we believe the state is required to intervene actively in society, including the economy, to promote and ensure justice and to redress inequalities.
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> **Poverty.** Cabinet believes that poverty is an evil, which must be overcome. Poverty is more than simply the lack of money; it is also a condition, which involves the experiences of shame, powerlessness, and social and political exclusion. Whilst being a necessary pre-requisite, genuine human development, requires more than the improvement in the material and economic aspects of life. Cabinet believes that there are more than enough resources within the world to create sufficient wealth to provide genuine well being. Cabinet calls for a redistribution of this wealth in ways that do not cause further social and economic disadvantage or ecological degradation.

Congress believes that these principles are consistent with the United Nations Declaration of Human Rights Article 25. (1), "Everyone has the right to a standard of

living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." [United Nations 1998]

And further aligns this view with the People's Charter for Health that states, "Governments have a fundamental responsibility to ensure universal access to quality health care, education and other social services according to people's needs, not according to their ability to pay". [People Health Assembly 2000]

History.

For many years Aboriginal people in central Australia were forced to live under highly regulated domestic civil laws that attempted to control our every move. At the same time we were left to the vagaries of the free market when it came to the economic sphere. In the civil sphere we were excluded from access to services and denied the rights of other citizens. In the free market, we experienced what happens when businesses are left to make the rules, for example Aboriginal workers were exploited through under pay (or non-payment) for their labour in the pastoral industry. Much of the wealth that has been generated within our region has been at the expense of Aboriginal labour or the exploitation of our land by un-feted free market practices.

Since the 1960's through to the 1980's Aboriginal people have successfully fought for the extension of many civil rights protections for our people, the historic Gurindji struggle, led to the recognition of Aboriginal workers within the regulated wage system. From the 1970's Aboriginal organisations, such as Congress have established the Indigenous rights agenda within central Australia, and have successfully modelled the strengths and successes of Aboriginal community-controlled organisations in addressing our peoples needs.

Congress continues to press for governments to meet their service obligations to Aboriginal people. In health, education and housing, governments continue to fail to adequately provide the same services to Aboriginal people that non-Aboriginal people enjoy. However Congress believes that it is Government's responsibility to ensure that these (and other services) are made both available to, and accessible by Aboriginal people.

Strong central government responsibility for health service delivery has been identified as a key determinant in the relatively smaller life expectancy discrepancy between non-Indigenous and Indigenous populations [Kunitz 2000]. For example in the USA[1], Canada & NZ, where central governments have taken responsibility for Indigenous health, indigenous people have a life expectancy gap of around 5-8 years, whereas in Australia, this is figure is around 20 years.

Implication of the free market.

Therefore we view with concern any diminishment of government's role in delivering services, through the privatisation of key services such as water, health or education.

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[1] The United States Indian Health Service, established initially under the Bureau of Indian Affairs, is one of the few vertical health services provided by the United States Government to its citizens.

For people in marginalised social positions and remote geographic locations we are sceptical that the private sector would either fill this void or provide services at affordable rates and believe that we would have little to no leverage upon these institutions to effect policy change in this issues[2]. In turn the downsizing of government offices may lead to a point that could severely limit its capacity to deliver services in remote areas or regions of low income per capita- often seen as economically un-attractive by private enterprise, as government infrastructure (including skilled workforce) may end up being so diminished that there is no real capacity to support service delivery for these sectors.

Against this background Congress views with concern the expansion of the neo-liberal economic agenda that currently dominates the free trade negotiations in both the General Agreement on Trade in Services (GATS) in the Doha Development Round of the World Trade Organisation and the Free Trade Agreement with the United States.

The history of trade negotiations has been that those with the most power have been the ones most strongly promoting free trade, often having followed a path of protectionism for the establishment of their own industrial base. US President Ulysses S Grant (1868-1876) said, "Within 200 years, when America has gotten out of protection all that it can offer, it too will adopt free trade." [Chang 2003] It would seem that that stage in history has now arrived. Congress believes that it is now the turn of the Australian government to place similar caveats upon any support for further trade liberalisation, particularly in the services sector.

The disproportionate power imbalance between large trading corporations and marginalised local communities, and between large national economies such as the USA and relatively small economies such as Australia, we believe does not allow for fair negotiations leading to equitable outcomes for all affected parties, including remote or socially marginalised communities.

While economic neo-liberalism has fuelled considerable economic growth this has not been translated into improved standards of living for the majority of the population. It has often led to increased social inequality. As a result of the application of neo-liberal economic policies through the World Bank and International Monetary Fund we have witnessed a marked decrease in access to health care services and a concomitant increase in diseases and a lowering of many populations health status internationally- most notably in third world countries. The assumption that economic growth leads to improvements in population health is commonly held, but not proven by the historical record. What the wealth creation generated by such outbursts of economic growth creates is the longer term potential for population health improvements, dependant upon political and social decisions on how it will be utilised. "The historical record clearly shows that the process whereby this wealth is created- economic growth itself- has no direct, necessary positive implications for population health. Indeed, in almost every case, the first and most direct effect of

[2] The average wage for Aboriginal people in Alice Springs estimated at $200 [ASTC 2000] would indicate a population that would struggle to afford full user pays health or education services and such a scenario would most likely emulate the situation experienced in third world countries where the population is priced out of utilising these services, putting further pressure upon the viability to provide the services in that region.

rapid economic growth has been a negative impact on population health" [Szreter 2003].

What is being proposed under the current GATS negotiations is the diminishing of the capacity of nation states to direct the wealth generated by economic growth into social equalisation programmes. A nations domestic policy would be subordinated to international trade obligations. Under the proposed GATS regime, domestic policy sovereignty would be undermined by the ad hoc development of a body of trade laws by GATS tribunals operating beyond public scrutiny. The proposal to ensure that any domestic regulation is not unnecessarily burdensome upon free trade, places this trade agenda above that of the states role in ensuring the safety of its citizens. These laws, aimed at maximising market openness, severely limit and restrict the scope of domestic policy, particularly in the areas of public and population health.

Key areas.

Government provision of services, under Aboriginal community-control.

As stated earlier Congress believes that it is a fundamental responsibility of governments to provide or to ensure the provision of those citizenship rights that relate to health services (and other services education, environmental health etc) ie the right to enjoy all the standards to access that the non-Aboriginal community. We believe that this can best be ensured through the government retaining its commitment to support Aboriginal community-control of those health services.

These twin tenets would guarantee Commonwealth responsibility to fund Aboriginal health services to a level required for Aboriginal people to enjoy similar health status as the non-Aboriginal population and that these services were delivered under Aboriginal community-control. Implicit in this understanding is that Aboriginal health will require additional funding levels than that provided to the non-Aboriginal population. This is based on two factors. As recognised in the Primary Health Care Access Programme (PHCAP), until such time that an equalisation of Aboriginal health status with that of the non-Aboriginal population is realised, a multiplier will have to be applied to the per capita health expenditure figure being allocated and accessed through the Medical Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) and other funding sources. As well, in order to effectively resource the community-controlled organisational process additional funding is required to facilitate thorough and effective community participation, management and board control. This would be an on going additional allocation that recognises the centrality of Aboriginal self-determination in effective programme and service delivery and governance[3].

No trade negotiation agreements should threaten the government's ability to meet its responsibility and commitment to support the extension of Aboriginal community-control of health services.

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[3] RCIADIC 1991

Universal health schemes vs the free market.

Whilst there is on going debate around the national universal medical scheme Medicare, the right of a country to either have or not have such a scheme should be driven by that countries decision making processes, not by a set of trade regulations that may deem it a block to free trade. Where such a debate occurs it is clear that the free market alternative, as exemplified by the United States health insurance system, does not deliver adequate population health coverage.

Under Medicare access to health care is based on need, not ability to pay, and this contrasts with the situation of inequitable access to hospital care under the previous 'Page Plan' [4] where by the late 1960s 'seventeen percent of all Australians had no insurance or access to public benefits and a further proportion were underinsured' [Swerissen and Duckett 1997].

In the US, where the health system is largely financed through private health insurance (PHI), with 4% of the world 's population that country spends more than $1 trillion yearly on health care, 35-40% of the global expenditure- one in six or more than 40 million Americans have no coverage at all. Access to high quality health care for the majority of the population is one of Medicare's achievements.

One of the principle determinants of the health of populations is access to quality health care and there is a clear socio-economic gradient for population morbidity and mortality [Wilkinson and Marmot 1998; Wilkinson 1996; Evans et al 1994; Caldwell 1986]. Medicare, therefore, plays an essential role in promoting population health both by providing universal access to quality health care and because it is a mechanism through which wealth is redistributed as the rich pay more through higher taxes and levies [Donato and Scotton 1999].

When compared with other health systems, such as the US, Medicare appears to be delivering better population health outcomes at less cost and it therefore has an excellent international record [Donato and Scotton 1999]. In 1997-1998 Australia spent $43.7 billion on health care which was 8.4 per cent of Gross Domestic Product (GDP) [AIHW]. In Canada the universal health insurance Medicare system accounts for 9% of GDP and 15% of government spending. These systems far outstrip the US system for efficiency, where healthcare accounts for 16% of US GDP and 19% of total public spending.

One of the major reasons for this impressive cost containment appears to be because about two thirds of health expenditure in Australia is publicly financed and it has been suggested that, if per capita GDP is held constant, greater public sector financing of health systems reduces the overall proportion of GDP spent on health [Gerdtham et al 1992]. Thus, in the US around half of health care expenditure is privately financed and they spend 16% of their GDP on health care - the highest of all OECD countries. The UK has one of the lowest cost health systems spending just 7% of GDP on health care with less than 20% private [Donato and Scotton 1999]. Research evidence also

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[4] The Page Plan was the national health insurance scheme introduced by the Menzies Liberal government in 1951. It was a 'two tiered' health system based on private health insurance and government subsidies with a safety net so that only the uninsured 'genuinely needy' could receive free public care.

refutes the claim that privatisation of hospitals reduces government deficit via capital savings and improvements in recurrent costs and creating greater efficiencies, by showing that 'for profit' hospitals actually increase the costs on the public purse, spending more on administration- particularly executive wages [Silverman et al 1999]. So Medicare is effective at controlling costs but what about health outcomes? It is generally accepted that indicators such as life expectancy, mortality rates at all ages and low levels of serious morbidity among non aged members of the population are criteria upon which we can judge the effectiveness of a health system at a population level. Measured by such outcomes 'health in Australia has improved considerably in recent decades, and compares favourably with most other OECD countries' [Donato and Scotton 1999].

Medicare is very popular with Australian consumers because it is meeting their 'wants' better than previous systems based on PHI [Donato and Scotton 1999] This is partly because a greater reliance on the public sector means 'the medical-industrial complex' [5] has less ability to influence or 'capture' health policy making for their own ends as opposed to the 'wants' of consumers [Navarro 1992]. Many commentators on the Clinton Administration's failed attempt to reform health insurance in the US point to the strong and vocal opposition mounted by private health insurers and the medical profession.

Australia should strongly oppose the opening of the health services to the free trade agenda. Australia along with many other countries operates a successful publicly funded health care system based upon pooled risk principles. Falling returns for US based health companies seeking new market opportunities should not be basis upon which Australian health care policy is premised. Rather Congress calls upon the Commonwealth to ensure that the coverage of the Medicare system is assured as a means to underwrite the implementation of the Primary Health Care Access Programme emergent Aboriginal Health Boards to successfully implement the scheme in their zones. And that free trade negotiations do not place limits on the governments ability to effectively extend either Medicare or the PHCAP.

Pharmaceuticals.

Congress believes that the Pharmaceutical Benefits Scheme (PBS) is the pre-eminent pharmaceutical purchasing system in the world and has led to Australian drug prices being as low as 60% of OECD average. The Pharmaceutical Benefits Advisory Committee (PBAC) plays a key role in assessing the cost effectiveness of drugs and making recommendations about their listing on the PBS based upon benefit to the Australian Community. This and the provision of Section 100 coverage to our health services has ensured that our clients can access essential pharmaceuticals and thus maintain a compliance regime for effect treatment programmes.

Both the PBS and the PBAC have come under attack from overseas-dominated pharmaceutical industry groups and companies (including from within Australia by their local subsidiaries) as being forms of blockage to free trade and open access to

[5] A term used by Navarro to describe industry lobbies of the medical profession, insurance agencies, private hospitals and other commercial interests in health care such as pharmaceutical companies and medical equipment manufacturers.

the Australian market. These schemes have been specifically targeted by the Pharmaceutical industry as part of the proposed Free Trade Agreement between Australia and the United States. [Mellish 2003, Maher 2003].

Congress calls for the Commonwealth government to ensure that nothing in any free trade agreements entered into limit its ability to maintainor extend the PBS or the independent functioning of the PBAC.

Regulation for public health standards.

In the area of domestic policy, no trade agreement rules should restrict the regulatory ability of national, state or territory or local governments, particularly in the areas of public health. Such laws would include clinical licensing, the setting of professional qualification standards, controls on the distribution and sales of tobacco, alcohol and firearms, privacy legislation, needs based health funding models, occupational health and safety and the standards for health infrastructure- including water and sewage systems.

Congress has put considerable effort into achieving alcohol availability restrictions within the Northern Territory in order to address the overwhelming public health issue involved in the excessive consumption of alcohol in this jurisdiction. These measures have included restrictions on trading hours and restrictions upon the size and nature of beverage containers. All such measures have been a deliberate attempt to restrict trade in this substance in order to affect a public health outcome. Congress would be greatly concerned if there were to be any limit of the government's ability to regulate in these matters under any free trade agreements.

Recommendations & other matters related to the inquires terms of reference

The relevant issues involved in the negotiation of the General Agreement on Trade in Services (GATS) in the Doha Development Round of the World Trade Organisation and the negotiations for a Free Trade Agreement between Australia and the United States, including but not limited to:

(a) the economic, regional, social, cultural, environmental and policy impact of services trade liberalisation and a USA/Australian Free Trade Agreement.

Congress believes there should be a government inquiry to assess the impact of free trade agreements on population and public health, and other social determinants including case studies from Australian and overseas.

(b) Australia's goals and strategy for the negotiations, including the formulation of and response to requests, the transparency of the process and government accountability.

Congress believes that any free trade negotiations should be open and transparent and provide opportunities for NGO scrutiny- possibly modelled on UN Treaty negations. Such agreement should be submitted to Parliamentary scrutiny to gain consent before being implemented.

(c) the GATS and USA/Australian Free Trade Agreement negotiations in the context of the 'development' objectives of the Doha Round.

Congress believes the Australian delegation should place in primary position obligations to human rights and Indigenous Human Rights Charters, as represented by the Draft Declaration of Indigenous Peoples Rights above those of the neo-liberal free trade agenda and achieving access for Australian businesses overseas.

(d) the impact of the GATS on the provision of, and access to, public services provided by government, such as health, education and water, &
(e) the impact of the GATS on the ability of all levels of government to regulate services and own public assets.

Congress believes that trade negotiations and agreements should not threaten the government's ability to meet its responsibility and commitment to support the extension of Aboriginal community-control of health services.

We believe that governments should ensure the quarantining of the health sector from the GATS free trade negotiations; this could be based upon the self-defining exemptions provided for national security issues under GATS articles.

Congress considers that the government must retain the right to provide health care services that address public and population health needs and that government retains the right to define those needs- including extending the scope of such health care services so as not to be interpreted under GATS rules as being an expropriation of private industry domain leading to compulsory compensation, this would particularly relate to universal health insurance risk pooling such as Medicare and the Pharmaceutical Benefits Scheme and the Pharmaceutical Benefits Advisory Committee.

In the area of domestic policy, no trade agreement rules should restrict the regulatory ability of national, state or territory or local governments, particularly in the areas of public health. Such laws would include clinical licensing, the setting of professional qualification standards, controls on the distribution and sales of tobacco, alcohol and firearms, privacy legislation, needs based health funding models, occupational health and safety and the standards for health infrastructure- including water and sewage systems and other infrastructure and service delivery standards.

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