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RESEARCH PAPER

How does policy framing enable or constrain inclusion of social determinants of health and health equity on trade policy agendas?

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\textbf{ABSTRACT}

Trade agreements influence the distribution of money, goods, services and daily living conditions – the social determinants of health and health equity, which ultimately impacts differentially on health within and between countries. In order to advance health equity as a trade policy goal, greater understanding is needed of how different actors frame their interests in order to shape government priorities, thus helping to identify competing agendas across policy communities.

This paper reports on a study of how policy actors framed their interests for the Trans Pacific Partnership agreement. We analysed 88 submissions made by industry actors, not for profit organisations, unions, researchers and individual citizens to the Australian government during treaty negotiations. We show that policy actors’ ideas of the purpose of trade agreements are shaped by competing underlying assumptions of the role of the state, market and society. We identify three primary framings: a dominant neoliberal market frame, and counter frames for the public interest and state sovereignty. Our analysis highlights the potential enabling and constraining impact of policy frames for health equity. In particular, the current dominant market framing largely excludes the social determinants of health and health equity. We argue that advocacy needs to tackle head on the underlying assumptions of market framings in order to open up space for the social. We identify successful examples of health framing for equity as well as opportunities for engagement with ‘non-traditional’ allies on shared issues of concern.

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Social determinants of health equity; trade; Trans Pacific Partnership agreement; health in all policies; healthy public policy

\textbf{Introduction}

Contemporary liberal capitalist democracies sit in tension between two often competing policy goals: on the one hand, pressures to sustain continued economic growth by facilitating capital accumulation; on the other, accountability to their citizens for public policies that meet societal objectives (Schrecker, 2009). These goals can come into conflict when societal objectives and market interests collide, creating challenges for governments in reconciling competing pressures. Public health has long recognised these tensions and has promoted the prioritisation of ‘healthy public policy’: the consideration of potential health impacts of multisectoral policy across sectors (Kemm, 2001). From the Alma Ata Declaration (1978), to the Ottawa Charter for Health Promotion
Trade policy is one domain where market and social and health interests can collide. Trade liberalisation agreements are generally argued to be necessary for national and global economic growth and aggregate social welfare gains (Stiglitz, 2017). Recent econometric studies find that, on average, trade liberalisation is associated with economic growth, although the scale of trade-related growth is both marginal and inequitably distributed within and between countries, with poorer countries potentially losing out under some agreements (Sundaram & Arnim, 2009; Tausch, 2016). Trade agreements also contribute to the diffusion of knowledge, goods, services and technologies across borders, with potential health benefits (e.g. via increased employment opportunities or improved access to health-promoting goods and services) as well as health risks (e.g. through downwards wage pressures, creating barriers for access to medicines, or increased marketing and supply of unhealthy commodities) (Battams & Townsend, 2018; Friel, Hattersley, & Townsend, 2015; McNamara, 2017; Schram et al., 2017; Thow et al., 2015; Townsend, Gleeson, & Lopert, 2016).

The potential impacts of such agreements on this broad range of social determinants of health (SDH) and health equity has led to repeated calls from public health experts and civil society groups for governments to give greater priority to health considerations in trade negotiations (McNeil et al., 2017; Ruckert et al., 2016). Scholars have increasingly called for governments to use Health Impact Assessments (HIA), which have been shown to be effective to provide evidence-based recommendations on the potential health and equity implications of provisions in trade and agreements (Hirono et al., 2016). To date, however, most health issues, and notably those pertinent to social determinants of health and health equity, appear to have remained on the periphery of governments’ consideration, secondary to market interests. One example of where a health mandate has entered onto the trade agenda is the European Union’s ‘Trade for All’ policy (2015, p. 22) which states that trade should ‘go hand in hand with social justice, human rights, high labour and environmental standards, and health and safety protection.’ However, this elevation of the ‘social’ has yet to occur in most countries, which may in part be due to the use of other dominant framings amongst key policy actors.

There are different ways to understand why market issues have tended to trump health or social concerns during trade treaty negotiations. One analytical stream, building on critical political economy, views the proliferation and deepening of trade and investment regimes as an outgrowth of neoliberal economic theory, which gained political prominence in response to economic recessions of the 1970 and 1980s and globalized through the structural adjustment programs advanced by the World Bank and International Monetary Fund (Quiggin, 2010; Stiglitz, 2017). While the term has many contested interpretations, neoliberalism generally is seen as ‘referring to the new political, economic and social arrangements within society that emphasize market relations [and] re-tasking the role of the state,’ extending a discourse of ‘competitive markets into all areas of life’ (Springer, Birch, & MacLeavy, 2016, p. 2). The reconfiguration of the role of the state under neoliberalism has enabled a shift away from a collective view of society to a focus on the individual as a self-interested rational actor, ‘legitimising the reduced role of the state and the elimination of even limited entitlements by redefining citizenship in terms of labour market participation and responsible consumption’ (Schrecker, Chapman, Labonté, & De Vogli, 2010, p. 1521).

Another analytical approach, not incommensurate with the one above, focuses on how and why certain policy goals do or do not get on government agendas by studying the agenda setting phase of the policy cycle. In this early stage, different actors and interests compete for prioritisation to get their issues onto the policy agenda. In this paper we take a constructivist approach to analysing this phase, which recognises that policy actors ‘bring their own values to the policy process, which influences their view about what is valid and relevant and what should command the attention of governments’ (Maddison & Dennis, 2009, p. 124). A constructivist approach focuses on how policy objectives and
issues are framed by policy actors (see the work of Carol Bacchi, 1999). In this instance, we can use submissions to identify how policy actors are framing the purpose and objectives of trade agreements, and whether such frames are either enabling or constraining for health.

Framing is recognised as an important strategy used to influence government agendas, including trade agreements (see Friel et al., 2015; Neuwelt, Gleeson, & Mannering, 2015 for a framing analysis of industry actor’s views in trade policy documents; see Jenkin, Signal, & Thomson, 2011; for an analysis of food industry submissions). Policy actors use frames or narratives, often strategically, to focus attention to a particular issue and persuade others of its importance. If they are successful, their framing ‘resonates with public understandings, and is adopted as new ways of talking about and understanding issues’ (Finnemore & Sikkink, 1998, p. 897). In turn, dominant framings can become so widely accepted that they become taken for granted as self-evident truths. The task for public health advocates in the contested terrain of trade and investment liberalization is to identify, reveal and challenge dominant framings that constrain competing arguments that support addressing the social determinants of health equity. Accordingly, this paper explores how varying policy actors frame their interests to influence government during trade and investment negotiations and to what extent these framings foster or constrain incorporation of the social determinants of health equity. We use the Trans Pacific Partnership agreement (TPP) as a case example of the trade policy domain. This framing analysis is part of a broader case study examining agenda-setting and the social determinants of health in the context of trade, within a larger comparative project on policy research for the social determinants of health equity funded by the Australian National Health and Medical Research Council.

Methods

A regionally-focused trade and investment agenda has emerged largely in response to stalled negotiations at the multilateral World Trade Organization level. The TPP, initially negotiated between the United States, Australia and ten other Pacific Rim countries and signed in February 2016, has been regarded as one of the more significant examples of this trend. In January 2017, newly elected President Donald Trump withdrew the United States from the agreement, arguing that it would harm the US economy (ABC News, 2017). At the time of this article’s publication, the Australian government and remaining ten countries had agreed in-principle to a near identical version of the agreement (with some key provisions suspended largely affecting intellectual property rights for biologic medicines that the US had been demanding), and renamed the ‘Comprehensive and Progressive Agreement for Trans-Pacific Partnership’ (CPTPP) (DFAT, 2017).

This paper is based on an analysis of submissions made by policy actors to the Australian government during the TPP negotiations. Although the TPP (and now CPTPP) is a signed treaty awaiting ratification, and so this analysis is retrospective, it remains important because it illustrates the types of actors seeking to influence government trade policy objectives, their differing interests and objectives, the framing strategies they employ, and whether or not arguments to address the social determinants of health equity are made. Understanding these competing frames can improve public health lobbyists’ abilities to identify and promote policy frames that are more enabling for positioning the social determinants of health equity higher on governments’ future trade agendas.

We accessed 88 publicly available submissions on the Australian Government’s Department of Foreign Affairs and Trade website received from policy actors between October 3, 2008, when the Australian government announced its interest in joining the TPP, and October 5, 2015 when those formal negotiations concluded. More than half of the submissions were made by commercial entities including industry associations, sector-specific industry bodies and commercial companies (See web appendix, S1). Not for profit organisations (NFPs) and researchers contributed 14.8% of
submissions respectively, followed by individual citizens (10.2%), unions (4.5%), public universities (2.3%) and local government (1.1%).

We sought to answer the following questions:

(1) How did the different policy actors frame their ideas of what should be the Australian government’s policy goals for the Trans Pacific Partnership agreement?

(2) Were arguments for addressing the social determinants of health equity represented? If so by whom?

One researcher developed a draft coding scheme informed by framing analysis, which was subsequently revised following initial coding by two researchers. The coding scheme sought to identify (1) actor type, (2) actor primary interest, such as market exporter, importer, or national health and welfare, (3) whether the actor supported Australia’s participation in the TPP, (4) the policy actor’s framing of ‘problems’ that should be addressed and solutions proposed, and (5) whether arguments around social determinants of health and health equity were made.

**Results**

We identified three primary framings: the most dominant frame – a neoliberal market frame – and two counter frames – a public interest frame and a state sovereignty frame. The following section explores each of the three frames, within which we examine how the ideas and assumptions underpinning each frame shaped policy actors’ interests as they sought to influence the government trade agendas, as well as how the frame either fostered or constrained attention to the SDH and health equity. The identification of actors by policy framing reflects the dominant frame in their submission. Sources are indicated by [submission source, date].

**The market frame**

The dominant frame emerging from our analysis is illustrative of neoliberal ideas and assumptions outlined above. According to this framing, markets operated by self-interested rational actors are seen as the most effective mechanism to advance society and promote human wellbeing, while government policies and regulations that are perceived to unnecessarily restrict markets are strongly criticized. The role of the state within this framing is therefore limited to facilitating and enabling private enterprise. This framing was evident in all industry actor’s submissions (n = 46), two submissions by public universities, and three submissions by academic researchers, together comprising more than three quarters of all submissions.

The primary interests of policy actors using this framing were market-oriented to increasing exports from Australia (47.7%), producing and selling within the domestic market (23.79%), or increasing imports into Australia (22.7%). Industry actors framed the ‘power of competition and free enterprise’ as a key driver of ‘long term prosperity’ for the Australian economy [General Electric, 2012; Export Council of Australia, 2014]. Market assumptions that economic benefits will ‘trickle-down’ to all were reflected in statements that trade reforms will ‘be passed on to consumers’ [Export Council of Australia, 2014] and be ‘of great benefit to Australia as a whole’ (Minerals Council of Australia, 2008). A limited role for the state was a common theme of these submissions, which shared a narrow view of government regulation as either enabling or restricting market access. For example, while acknowledging the importance of regulatory processes for safety and efficacy, the Medical Technology Association of Australia [2010] framed regulatory processes as barriers for access to markets. Some submissions, such as the Winemakers Federation of Australia (2010), went further, framing some consumer protection and ‘fair trade’ regulations in other countries as creating ‘unnecessary’ market access barriers.
The key objective of policy actors within this framing was expanding market access in the region through increased export and import liberalisation (see web appendix, S2). Export liberalisation was framed as “essential” for the survival and ongoing growth of Australian industry, and of benefit for all in the region through ‘mutual prosperity’ [Navitas, 2012]. Policy actors particularly prioritised the reduction of tariffs and other government regulatory settings perceived to constrain their market access or disadvantage their economic interests.

Harmonisation of regulatory settings across TPP countries was another key objective, framed as creating an inherent benefit to industry and society. The American Chamber of Commerce in Australia (2010) called for the ‘…highest possible degree of harmonisation in particular countries’ regulatory environments.’ Several submissions emphasised the need for simplicity, consistency, coherence and harmonisation between existing FTAs and the TPP. These seemingly neutral terms reflect an agenda for changing governments’ regulatory approaches, often down to the lowest denominator for industry benefit. If you take for example calls for ‘harmonisation’ between governments on the regulation of medical devices, the ‘leading example’ or level of regulation sought by industry is one of less regulation. Thus, ‘harmonisation’ framing is often co-opted for private interests.

Within this lens, Australia’s own regulatory settings were also viewed as creating barriers for market access. Accord Australasia, the national industry association of marketers and manufacturers of hygiene, cosmetic and specialty products, framed Australia’s regulatory requirements regarding the manufacture, importation and supply of medical devices as ‘overly complex, fragmented and… out-of-step with that of other advanced nations’ and ‘a barrier to the introduction of new technologies’ [2011]. Accord concluded that the TPP could be used as a mechanism to ‘help focus local effort’ on reforming Australia’s regulation.

Intellectual property rights (IPR) was another common theme, with policy actor’s objectives reflecting their specific economic interests. Some actors framed a ‘strong’ commitment to IPR in the TPP as a key objective to resolve the problem of ‘IP theft in Asia and South America’ [Australian Recording Industry Association & Music Industry Piracy Investigation Pty Limited, 2008]. Other industry actors, however, were opposed to the inclusion of IPR in the TPP. In particular, the generic pharmaceutical firm Alphapharm, Australia’s leading supplier of prescription and generic medicines by volume, expressed ‘deep concern about the impact that the TPP could have on the generic pharmaceutical industry in Australia’ [2011]. Others such as Open Source Industry Australia & Linux Australia [2014] framed IPR as creating ‘bottlenecks’ that stifle competition. Both of these competing approaches to IPR come from a market orientation in that they are centrally concerned with private enterprise. However, they also illustrate competing uses of market frames and opportunities for public health advocates to engage industry actors on issues of common concern, which we will come back to in the discussion.

More than half of proponents of the dominant market framing explicitly supported Australia’s participation in the TPP. A common rationale was the view that the TPP could become a ‘gold-standard 21st century agreement’, and the basis or ‘blueprint’ for a broader regional Free Trade Area of the Asia Pacific [Australian Pork Limited, 2013]. Australia’s participation in the TPP was seen as key to influencing the ‘ground rules’ for future agreements [Australian Sugar Industry Alliance, 2008]. Two industry actors opposed the TPP and several submissions supported or opposed another country joining the TPP, based on their economic interests. In particular, industry actors with economic interests in Canada supported Canada’s participation in the TPP, while some Australian export groups, such as the Australian Dairy Industry Council [2012] framed Canada as a protectionist country.

The market frame was particularly constraining for arguments to address the social determinants of health. Policy actors who promoted the market frame mainly referred to only two economic determinants of health in their submissions; gross national income and crude employment figures. This focus on economic determinants reflects the underlying assumption of the market framing; that markets will improve society and human wellbeing through continued economic growth. Reference to other social determinants of health were notably absent in these submissions, consistent with the
neglect of the ‘social’ within this framing. Arguments on addressing inequities within or between countries were also largely absent in submissions clustered under the market framing.

Public interest frame

The first counter framing to the dominant neoliberal market discourse is illustrative of the (predominantly civil society) pressure on governments to place public social and health interests above private market interests, or at least ensure that private market interests do not compromise the provision of public goods and services. It is a counter framing insofar as it challenges somewhat the neoliberal notion of self-interested individuals by asserting the importance of collective interests and rights, in this case as these relate to trade policy agendas. Proponents of this counter framing emphasized the importance of placing ‘public interest over private profit’ [J Harvey, N.D].

At the core of these submissions was a view that government must play a role in ensuring ‘a fair go for all’ [Civil Liberties Australia, 2015]. This societal framing was the dominant framing in more than a quarter of policy actor submissions, including submissions by individual citizens (n = 6), not-for-profit organisations (n = 8), unions (n = 3) and academic researchers (n = 3).

The key objective of policy actors within this framing was the inclusion of regulatory settings and standards that reflected societal values and ‘fundamental human rights’ [J Harvey, ND]. Several policy actors also framed the TPP as a mechanism for the enforcement and monitoring of societal values. The Australian Fair Trade and Investment Network (AFTINET), for example, argued that the TPP should enforce labour rights and include market penalties such as trade sanctions for countries that violate labour and human rights [2008]. Several submissions also argued that international agreements for the environment, conservation, labour, health, and the rights of Indigenous peoples should have ‘primacy’ over trade agreements like the TPP should conflicts arise.

Another common theme within this societal framing was calls for Australia to prioritise and conduct social, cultural and environmental impact assessments of trade provisions. This included assessments of the impact on regional economies, wages and employment, environmental degradation, and measures to address climate change. This counter framing was also evident in a critique by some policy actors of the economic modelling used by government to inform decision making on trade; framed as insufficient because it did not consider social and environmental impacts [see Australian Fair Trade and Investment Network, 2008; Construction Forestry Mining and Energy Union, 2008].

Another key focus of these submissions was on re-embedding markets within government regulatory frameworks. Several submissions opposed the inclusion of any mechanism within the TPP that would provide investors with ‘disproportionate power’ and ‘undermine the democratic process’ [Australian Council of Trade Unions, 2010]. Indeed, some policy actors argued that the TPP should include mechanisms to enable the review of investments ‘to ensure it is in the public interest’ [AFTINET, 2008]. This framing was also evident in arguments around the inclusion of intellectual property rights. Several policy actors framed IP as a ‘threat to civil liberties’ and a risk to citizens’ privacy and freedom of expression [Burchett, 2014].

Another common theme within these submissions was a strong criticism of the Australian government’s processes for stakeholder consultation on the TPP. Policy actors criticised the ‘extreme secrecy’ [Civil Liberties Australia, 2015] around the negotiations and considered Australia’s processes to be insufficient. These arguments reflected the core assumption of the society framing; that public input is required to ensure that policymaking will be ‘for the benefit of society’ [La Forgia, 2012]. Several policy actors therefore called for the government to release the negotiating text for public and parliamentary scrutiny.

No actors emphasizing the importance of a societal framing explicitly supported Australia’s participation in the TPP. Several indicated that their support or opposition would be based on the final agreement aligning with specific social and health objectives that they considered important. For example, the Australian Medical Students Association [2013] asserted that the agreement
‘should not come at the cost of the region’s capacity to deliver cost effective healthcare to those who need it the most.’ Five submissions within this framing explicitly opposed Australia’s participation in the TPP, arguing that the agreement was ‘a danger to the freedom of citizens to decide their own democracy’ [Civil Liberties Australia, 2015], or benefiting multinational corporations at the expense of the national interest.

The public interest framing appeared to be more enabling of evidence and arguments for the social determinants of health than the dominant market frame. Several SDH were raised as policy concerns including access to affordable medicines, employment conditions and workers’ rights, sustainable economic development, food safety, human rights, the retention of public health services, access to knowledge and technology and the regulation of harmful commodities such as alcohol and fast-food (see web appendix, S3).

This counter framing challenged the assumptions of the market frame, with policy actors arguing that ‘workers are not commodities’ [Construction Forestry Mining and Energy Union, 2008], and that ‘public health concerns override economic or trade concerns where priorities may conflict’ [Hirono et al., 2016]. ‘Fair trade’ rather than ‘free’ trade was also used as a key term to invoke principles of fairness and societal values [Australian Council of Trade Unions, 2010].

While several SDH were raised by policy actors within this counter framing, few submissions made explicit reference to health equity, whether within or between countries, or for at risk population groups. One strong exception was the issue of access to medicines (See web appendix, S4), which were consistently seen as a ‘public good’, and where government intervention was ‘essential to ensure that affordable medicines are available to all’ [Public Health Association of Australia et al., 2013]. Access to medicines was linked to between-country equity through arguments for improving developing countries’ access to affordable medicines and medicines for neglected diseases. The issue of policy coherence, essential for improving health equity, was also made with reference to access to medicines [AMSA, 2013].

While access to medicines was the main SDH linked to equity and policy coherence, there were some minor references to equity for other SDH. Unions, for example, advocated for labour rights, sustainable economic growth, and public participation in decision making in all countries [Australian Council of Trade Unions, 2010]. Two submissions raised the issue of within-country equity for access to public services and for ‘unequal wealth distribution’ [Burchett, 2014; Freestone, 2015]. Several at risk population groups were also identified, including low skilled workers, farming communities, seniors, pensioners, low socioeconomic groups, Indigenous populations, and blind, visually impaired, or otherwise print-disabled persons.

**State sovereignty frame**

The third major framing evident in policy actors’ submissions was a concern for state sovereignty. This counter framing challenges the dominant market frame in which the state’s role is primarily defined as facilitating economic growth, to one which emphasizes the need to protect the right of states to regulate in the public interest. This ‘state sovereignty’ framing was evident in submissions by not-for-profit organisations (n = 6), academic researchers (n = 5), one union, one individual citizen and one local government submission.

Policy actors’ within this framing shared a common view of the ‘sovereign right’ of the state to strong and precautionary laws and regulations” [Gene Ethics, N.D]. A key objective was the preservation of the regulatory autonomy of the state across a number of policy settings such as health, environment, social protection and culture. Local government Byron Shire Council’s [2014] submission, for example, reflected its primary interest in preserving local government policymaking in areas such as promoting local employment, protecting local government supply, regulation and procurement. Submissions that reflected this dominant framing were mainly neutral on whether Australia should participate in the TPP, but indicated that their future support or opposition would be based on the implications of the agreement for the role of the State in regulation.
Policy actors within this framing were opposed to the inclusion of an investor state dispute mechanism (ISDS) in the TPP. ISDS is a mechanism that enables ‘foreign investors to seek compensation for certain breaches of a host state’s investment obligations’ through international tribunals [DFAT, 2017]. ISDS was framed as a mechanism that ‘gives unaccountable corporations and their narrow interests too much power over democratic governments and their right to legislate’ [Holyoak, ND] and a ‘fundamentally flawed system in the eyes of anyone who takes basic principles of democracy and fairness seriously’ [Tienhaara, 2010]. Some policy actors focused on the impact of ‘regulatory chill’ on government regulation due to perceived risks of investor arbitration [Tienhaara, 2010]. Others argued that if ISDS was to be included in the TPP, Australia should ensure ‘effective safeguards’ for public health matters [Health Impact Assessment, 2015].

Public health was a common theme with policy actors framing the right of the state to regulate in areas such as medicine pricing and production, labelling regulation for seeds, animals, genetically modified foods, pharmaceuticals and new technologies. More emphatically, one submission contended that it was ‘unacceptable that any confidential trade negotiation should seek to influence outcomes of government health policy in any way, shape or form’ [Consumers Health Forum, 2013].

As with the public interest framing, the state sovereignty framing was more inclusive of arguments around the SDH than the dominant market discourse. Policy actors using this framing focused on protecting the state’s right to regulate for a number of SDH, including government regulation in pharmaceutical reimbursement and pricing policies, public financing of R&D for medical innovations, government support for local employment, state protection of sacred Indigenous sites that serve as cultural determinants of Aboriginal and Torres Strait Islander health, and government regulation of harmful commodities. The issue of access to medicines was again most explicitly linked to equity, both within and between countries [Gleeson, 2012]. Public health researchers also called on the Australian government to conduct an official health impact assessment ‘with a focus on equity’ prior to signing the agreement [Hirono et al., 2016].

Several submissions within this state sovereignty framing also linked their arguments to at risk population groups. Byron Shire Council [2014], for example, raised concerns for the state’s right to regulate coal seam gas mining for rural communities. Public health researchers linked risks from reduced state regulation on tobacco control, alcohol and food labelling, and IP impacts on increased co-payments for medicines, for low socio-economic groups, Aboriginal and Torres Strait Islanders, youth, elderly, people with mental illness and chronic conditions, people in prison, drug users, and culturally and linguistically diverse groups [Hirono et al., 2016].

Discussion

The development of trade policy that pursues economic as well as social and health goals poses a classic ‘wicked policy problem.’ Understanding how trade policy agendas are set is an important aspect of such problems. Our analysis indicates the dominance of neoliberal market framing in trade policy agenda setting. This framing envisions a limited role for the state through the promotion of market interests, configures citizens primarily as ‘consumers’, and regards most public regulation as excessive or intrusive on producers’ economic rights. Within this discourse, there is little or no mention of collective or societal concerns apart from those indirectly related to market growth (i.e. employment gains through economic growth). Underpinning these ideas are an assumption that markets and growth are inherently positive; what is absent is any reference to potential negative social or health impacts (in market terms, ‘externalities’).

In contrast to the dominant market frame, we identified two other frames, predominantly amongst civil society and public health groups and scholars that attempted to counter these market assumptions by re-asserting the importance of government measures to prevent or reduce negative externalities and protect future state sovereignty to regulate for the public interest. Both counterframes brought forward arguments pertinent to the social determinants of health and health equity.
Both counter-frames, and notably those focusing on state sovereignty, explicitly or implicitly promoted the role of governments in regulating markets for the public good, and challenged the market discourse by prioritising public interests and consideration of broader societal values.

This analysis of framing illustrates the barriers for public health advocates in the trade policy domain, but also suggests enabling opportunities for further action. The dominant market framing poses a significant challenge because it excludes the SDH and frames state regulation within the purview of private actors’ interests. The assumptions underpinning free market trade and unfettered liberalisation are so pervasive amongst trade policy discussions that, despite evidence of counter-frames by civil society and health groups, the market/economic remit continues to dominate trade and investment discussions. This is apparent in the frequency of these concerns in the submissions we analysed, but also in the ways in which TPP/CPTPP governments themselves emphasized (and often initially exaggerated) the economic benefits of the agreement, with only unsubstantiated assurances that such agreements would not affect their abilities to regulate for health protection – a claim refuted by many health and trade policy analysts (Kelsey, 2012; Labonté, Schram, & Ruckert, 2016; Thow et al., 2015). The dominance of the framing creates difficulties for public health advocates who are often on the periphery of trade policy agenda-setting with fewer resources and less power to influence negotiations.

Our analysis, however, also illustrates opportunities for strengthening advocacy for SDH. In particular, it appears that more explicit engagement and critique of the assumptions underpinning the market frame may provide more space for counter frames to emerge. Such an approach could call on health advocacy to engage with heterodox economic studies that document the failures of ‘trickle down’ economics to generate wellbeing, and that provide explicit and evidence-informed critiques of market assumptions in terms of their medium- or long-term health impacts, as well as their population distribution. Another opportunity we identify in the submissions is the apparent divide amongst industry groups over intellectual property rights. As outlined in our results, several market actors, although arguing for their own economic interests, are opposed to the extension of intellectual property rights, providing health advocates with more ‘market-friendly’ allies on at least some facets of trade and investment treaties.

It is also worth reflecting on established frameworks already operationalised in public health advocacy. Health in All Policies (HiAP), as outlined in our introduction, provides a model for promoting intersectoral collaboration and the consideration of health across all sectors (Baum et al., 2017). Health Impact Assessments (HIA) are one tool for evidence-based input into policy development used successfully in several countries. In the context of trade policy, several public health groups and scholars contributed to a prospective ‘Health Impact Assessment’ of the TPP that was submitted to government and part of our analysis above [Health Impact Assessment, 2015]; while others have done so through parliamentary presentations in other TPP/CPTPP countries, such as Canada. These analytical frameworks remain important tools for bringing health equity evidence into the trade policy debate, although we note that there is still a long way to go for such evidence to trump market ideology. For this reason, we also suggest an explicit focus taking market-based assumptions to task so as to provide more space for the prioritisation of health evidence.

Finally, our analysis also points to differing prioritisation within the public health community for SDH and equity arguments in trade advocacy. While several policy actors raised various social determinants of health in their submissions, few submissions linked these to health equity, whether within or between countries, or in relation to specific at risk population groups. The issue of access to medicines was most explicitly linked to health equity concerns. We hypothesise that this prioritisation within the public health community may be driven by several elements. First, it can be seen as a strategic move by advocates to bring health issues into a dominant market-based agenda. A key element of improving access to medicines is the timely introduction of generic medicines to the market and to introduce price competition. This issue may be easier to advocate within a trade space currently dominated by market access objectives. Second, the negative impact that elevated intellectual property rights can have on access to medicines has a robust evidence-
base, and there is broad international support for limiting monopolies (Gleeson, Moir, & Lopert, 2015). Evidence of the impact of trade agreements on other SDH, and of health equity more generally, is less-well demonstrated empirically. Although there is growing evidence of the impact of trade and investment agreements on the global spread of health-harmful commodities (Baker, Friel, Schram, & Labonté, 2016; Schram et al., 2015), there is less consensus on the role played by trade treaties per se. Research on other SDH affected by trade agreements, such as changes in labour market or environmental conditions, is still nascent. Finally, the focus on access to medicines within the counter-frames likely reflects, at least in part, the continued dominance of a biomedical paradigm within the public health community. While there is significant evidence of the need to address the broader social conditions of people’s lives and the ‘causes of the causes’ (WHO Commission on the Social Determinants of Health, 2008), a medical, disease and treatment-based model for health still persists within the government, non-government organisations and academy (Baum, 2016). While access to medicines remains an important health issue, its dominating role in public health advocacy around trade and investment policy poses a challenge in bringing more attention to advancing broader social determinants of health lens to trade negotiations.

Within the Australian context and the TPP, it is noteworthy that Australia’s Joint Parliamentary Foreign Affairs, Defence and Trade Senate Committee (Parliament of the Commonwealth of Australia, 2017) did identify several ‘troubling aspects’ in their assessment of the original TPP. These included potential risks for governments over investment provisions, the potential undermining of labour market testing, a provision which requires industry to exhaust opportunities in local labour markets before applying for visas to bring in foreign workers, a lack of enforceable labour and environmental standards, and concerns over intellectual property rules for biologic medicines (Parliament of the Commonwealth of Australia, 2017, p. 35). Some of these issues re-emerged in discussions between Australia and remaining parties in the rebadged ‘CPTPP’ in late 2017. At the time of this article’s publication, as noted earlier, the remaining CPTTP countries have agreed to suspend a number of provisions, such as specific data monopolies on biologic medicines, unless a consensus-based decision is made to reintroduce them (DFAT, 2017). While public health advocates would prefer to see these provisions removed entirely, this provision nonetheless provides a real world example of the success of public health advocacy in this area and concrete evidence of progress in a challenging policy domain.

**Conclusion**

Shifting the dominant framing of trade policy agendas from a neoliberal market one to a broader societal discourse that re-embeds markets within society would support the advancement of the SDH and health equity in this policy space, subsequently enhancing greater policy coherence between trade and health equity. This is no easy task but one that requires health advocates to contest market assumptions and create new frames to bring the issues of society and health to the fore. We note that public health has made progress in achieving some concrete changes in trade agreements – the suspension of biologic medicines in the CPTPP being one example. Given the somewhat contested and competing international politics of trade and investment liberalization at the moment – with the US-led rise in protectionist rhetoric on the one hand, and attempts by other countries to introduce a more ‘progressive’ tone on the other – the space for continued efforts by public health advocates may now be considerably larger.

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