**Trade Agreements, Public Policy and Social Inequalities in Health**

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**Introduction**

Dozens of research studies and reports have documented the detrimental impact of trade agreements on population health (cf. Labonté et al., 2009; McNamara, 2017; McNeill et al., 2017). This is especially relevant in light of bilateral and regional trade agreements that have recently been signed (e.g. TPP) or that are currently proposed or in the process of development negotiation (e.g. TTIP). Research on the link between trade and health outcomes has paid considerable attention to issues of social justice and equity (e.g. Fox & Meier, 2009; Labonté et al., 2007; Meier, 2006; Ruckert & Labonté, 2012). However, few studies have expressed how social groups are affected differently by trade agreements, and therefore what consequences trade agreements might have for social inequalities in health. Additionally, while the field of comparative research on health inequalities has increasingly acknowledged and investigated the role of national public policy (e.g. Beckfield & Krieger, 2008; Blom, Huijts & Kraaykamp, 2016; Gesthuizen, Huijts & Kraaykamp, 2012), the impact of global factors such as trade agreements has remained largely ignored (see also McNamara, this issue).

The main aim of this contribution is therefore to explore how trade agreements affect social inequalities in health. Additionally, we offer suggestions on how the links between trade agreements and health inequalities could be assessed in comparative research on health inequalities. We focus on three areas of public policy that have an established impact on social inequalities in health (i.e., healthcare policy, public health policy, and social policy). Our central argument is that recent trade agreements increase the need for public policy intervention to counteract rising health inequalities, but at the same time reduce the capacity of national governments to invest in intervention.

**Public Policy and Health Inequalities in a Global Context**

The reduction of social inequalities in health is a key priority for policy makers at local, national and international levels (CSDH, 2008; Marmot, 2010). The observation that health inequalities exist in all societies but are much stronger in some countries than in others has further underlined the potential for public policy to actively diminish social inequalities in health (cf. Huijts & Eikemo, 2009; Mackenbach et al., 2008). This has resulted in an increasing number of studies over the past decade aiming to establish the impact of public policy indicators on health inequalities. On the whole, this body of research has focused on three domains of public policy that are most directly linked to social inequalities in health: (1) healthcare policy (e.g. healthcare access); (2) public health policy (e.g. taxation and regulation of health damaging substances); and (3) social policy (e.g. social security).

However, the global context has largely been ignored in research examining links between public policy and health inequalities. This is problematic, despite the fact that local and national governments are most directly involved in the design and implementation of healthcare policy, social policy, and public health policy. After all, actors and institutions at the global level influence and constrain local and national governments both directly and indirectly. Clear examples are the role that the World Bank’s Structural Adjustment Programmes and the IMF’s conditional loans have had in restricting expenditure on public policy during the past few decades. This embeddedness of local and national public policy in a global context can be better understood through the concept of policy space (e.g. Koivusalo, 2014): local and national governments are constrained in the extent to which they have room to adjust public policy due to restrictions that are imposed on them by global actors. This especially applies to countries in a position of economic dependency, and to countries that have been subject to economic shocks. As a result, to understand and examine the policy space of local and national governments to reduce social inequalities in health, we need to consider how global factors place constraints on healthcare policy, social policy, and public health policy. In the remainder of this article we focus on trade agreements as a case study of how each of these three policy domains can be constrained in their potential to reduce health inequalities by global factors.

**Trade Agreements and Restricted Policy Space to Reduce Health Inequalities**

In the domain of *healthcare policy*, trade agreements mostly affect policy space to reduce health inequalities by requiring market competition in the infrastructure and/or delivery of healthcare services. More specifically, trade agreements can open the infrastructure of public healthcare services to private investment, and have been associated with gradual privatization of healthcare services at the point of delivery (see e.g. Pollock & Price, 2000; Price, Pollock & Shaoul, 1999). Gradual privatization of healthcare services may lead to shifts in resources from public investment to private out-of-pocket and insurance expenditure, and countries where public provision and funding of healthcare is currently dominant (such as the United Kingdom) may gradually develop combined public/private models of healthcare provision. Taken together this may contribute to the development of a two-tier healthcare system, where private healthcare is mostly affordable for the wealthiest, of higher quality, and more responsive, whereas public healthcare will only be used by those who have no choice financially but to accept a lower quality of care and longer waiting lists. This would result in widening inequality between income groups in de facto access to good healthcare, which is likely to exacerbate social inequalities in health. In the context of trade agreements, national government investment to counterbalance unequal quality of care (e.g. by introducing income-dependent co-payments) is usually not possible; after all, this would be at odds with the principle of fair competition between investors.

Effects of trade agreements on *public health policy* have been documented extensively (for an overview see e.g. Shaffer et al., 2005). This is most evident in those areas of public health policy that involve the regulation and taxation of health damaging goods, such as tobacco, alcohol, and unhealthy foods. Trade agreements can restrict regulations on the sales, packaging and consumption of these goods, and such restrictions have become more frequent and profound due to the increased inclusion of investor-state dispute settlement (ISDS) clauses (see for example recent challenges to plain packaging of cigarettes on the grounds of copyright infringement). Similar clauses have been invoked in cases where local and national governments aimed to develop regulation of chemical products in order to protect environmental health. However, although the restricted policy space in public health policy as a result of trade agreements has been well documented, there has not been a great deal of attention for the differential vulnerability of social groups to these restrictions on regulation and taxation. To assess the full impact of trade agreements it is crucial to acknowledge that the public health policies targeted by them are likely to be most beneficial for the most vulnerable social groups. For example, people who do manual labour suffer the highest exposure of chemical hazards, and the stress that is conducive to addiction to tobacco and alcohol is most prevalent among people with low incomes and levels of education. As such, the restricted policy space in public health policy is likely to widen social inequalities in health, because reduced room for regulation and taxation on health damaging goods is mostly likely to harm those who are exposed most to these goods.

Finally, a main way trade agreements can affect *social policy* is through labour clauses. Restricted policy space in this domain may in theory be beneficial for health inequalities, if provisions lead to better labour standards. However, recent evidence suggests that labour clauses do not play a determinant role in improving labour standards (Giumelli, F., and van Roozendaal, 2017), and that they may actually damage employment relations to the detriment of health and health inequalities (McNamara and Labonté, 2016). Importantly, trade agreements also affect the living conditions and socioeconomic determinants of health that social policy aims to address (for an overview see e.g. Blouin, 2009; Muntaner et al., 2010; McNamara, 2017). For example, trade agreements have been associated with greater income inequality, poverty and economic insecurity (Labonté et al., this issue). Although trade agreements therefore increase the need for additional investment in social protection policies to deal with increasing levels of poverty and insecurity, in reality we rather see the opposite. Largely this is because trade agreements are often part of a broader package of neoliberal policies, including austerity measures to reduce public expenditure. As such, especially in the context of austerity, trade agreements are likely to go hand in hand with greater inequality in key socioeconomic determinants of health, with widening social inequalities in health as a result.

**Next Steps for Comparative Research on Trade Agreements and Health Inequalities**

All in all, then, it is clear that recent bilateral and regional trade agreements are likely to have a detrimental impact on health inequalities. In this light, there is a substantial need for comparative research to establish empirically which social groups are affected most, and in which countries local and national governments are most and least successful in protecting health within the boundaries of restricted policy space. There are myriad ways in which this could be approached in both qualitative and quantitative research, but here we offer a few examples of strategies that seem particularly promising. In country comparisons of relationships between employment, job insecurity and health, the focus could be on a limited number of labour market sectors that are particularly sensitive to changes in labour market regulation. The impact of changes in the public/private balance in the provision of healthcare could be examined by within- and between-country comparisons of regions to establish to what extent greater reliance on private healthcare is associated with stronger inequalities in health. The impact of changes in regulation and taxation of health damaging goods on health inequalities could be studied through a wider range of quasi-natural experiments, for example by comparing trends in countries with similar starting positions through difference-in-difference models (for an example see e.g. Vandoros et al., 2013). Finally, research focusing on the impact of austerity on health inequalities should consider the interplay between austerity measures and trade agreements in reducing policy space to protect those who are most vulnerable.

**Conclusion**

We have argued that trade agreements may exacerbate social inequalities in health through interaction with different dimensions of public policy. In general, rather than simply undermining public policy directly, trade agreements often limit the capacity of public policy to mitigate social stratification and its effect on health outcomes. However, this does not necessarily mean that we should be entirely pessimistic about the impact of trade agreements on health inequalities in the near future. The power of national governments to guard and reclaim public policy space should not be underestimated (Shaffer et al., 2005; Schrecker, 2016), especially with the support of civil society organizations. New comparative empirical research has the potential to further elucidate which social groups are most in need of social protection, and how local and national governments can buffer the impact of recent trade agreements on health inequalities, either by guarding or reclaiming policy space or by strategic interventions within restricted policy space.

**References**

Beckfield, J. & Krieger, N. (2009). Epi + demos + cracy: linking political systems and priorities to the magnitude of health inequities – evidence, gaps, and a research agenda. Epidemiologic Reviews, 31, 152-177.

Blom, N., Huijts, T., & Kraaykamp, G. (2016). Ethnic health inequalities in Europe. The moderating and amplifying role of healthcare system characteristics. Social Science & Medicine, 158, 43-51.

Blouin, C., Chopra, M., & Van der Hoeven, R. (2009). Trade and social determinants of health. The Lancet, 373, 502-507.

Commission on Social Determinants of Health (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Geneva: World Health Organization.

Fox, A.M. & Meier, B.M. (2009). Health as freedom: addressing social determinants of global health inequities through the human right to development. Bioethics, 23, 112-122.

Gesthuizen, M., Huijts, T., & Kraaykamp, G. (2012). Explaining health marginalization of the lower educated: the role of cross-national variations in health expenditure and labor market conditions. Sociology of Health and Illness, 34, 591-607.

Giumelli, F., van Roozendaal, G. (2017). Trade agreements and labour standards clauses: Explaining labour standards developments through a qualitative comparative analysis of US free trade agreements. Global Social Policy 17, 38–61. doi:10.1177/1468018116637209

Huijts, T. & Eikemo, T.A. (2009). Causality, selectivity or artefacts? Why socioeconomic inequalities in health are not smallest in the Nordic countries. European Journal of Public Health, 19, 452-453.

Koivusalo, M. (2014). Policy space for health and trade and investment agreements. Health Promotion International, 29, i29-i147.

Labonté, R., Blouin, C., Chopra, M., et al. (2007). Towards health equitable globalization: rights, regulation and redistribution. Globalization Knowledge Network Final Report to the Commission on Social Determinants of Health. Institute of Population Health, University of Ottawa.

Labonté, R., Ruckert, A., Schram, A. (2018). Trade, Investment and t­­­­­­­­he Global Economy: Are We Entering a New Era for Health?. Global Social Policy

Labonté, R., Schrecker, T., Packer, C., & Runnels, V. (2009). Globalization and health: Pathways, evidence and policy. New York, NY: Routledge.

Mackenbach, J.P., Stirbu, I., Roskam, A.J., et al. (2008). Socioeconomic inequalities in health in 22 European countries. New England Journal of Medicine, 358, 2468-2481.

Marmot, M. (2010). Fair society, Healthy Lives: the Marmot review. London: University College.

McNamara, C., Labonté, R. (2017). Trade, Labour Markets and Health: A Prospective Policy Analysis of the Trans-Pacific Partnership. Int J Health Serv 47, 277–297.

McNamara, C. (2017). Trade liberalization and social determinants of health: A state of the art literature review. Social Science & Medicine, 176, 1-13.

McNamara, C. (2018). Is trade policy the missing piece to a public health puzzle?.Global Social Policy

McNeill, D., Birkbeck, C.D., Fukuda-Parr, S., Grover, A., Schrecker, T., & Stuckler, D. (2017). Trade and investment agreements: implications for health protection. Journal of World Trade, 51, 159-182.

Meier, B. (2006). Employing health rights for global justice: the promise of public health in response to the insalubrious ramifications of globalization. Cornell International Law Journal, 39, 711-778.

Muntaner, C., Chung, H., Solar, O., et al. (2010). A macro-level model of employment relations and health inequalities. International Journal of Health Services Planning and Administration Evaluation, 40, 215-221.

Pollock, A. & Price, D. (2000). Rewriting the regulations: how the World Trade Organisation could accelerate privatization in health-care systems. Lancet, 9246, 1941.

Price, D., Pollock, A., & Shaoul, J. (1999). How the World Trade Organisation is shaping domestic policies in health care. Lancet, 9193, 1889-1892.

Ruckert, A. & Labonté, R. (2012). The global financial crisis and health equity: Toward a conceptual framework. Critical Public Health, 22, 267-279.

Schrecker, T. (2016). Globalization, austerity and health equity politics: taming the inequality machine, and why it matters. Critical Public Health, 26, 4-13.

Shaffer, E.R., Waitzkin, H., Brenner, J., & Jasso-Aguilar, R. (2005). Global trade and public health. American Journal of Public Health, 95, 23-34.

Vandoros, S., Hessel, P., Leone, T., & Avendano, M. (2013). Have health trends worsened in Greece as a result of the financial crisis? A quasi-experimental approach. European Journal of Public Health, 23, 727-731.