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RESEARCH PAPER

Policy coherence, health and the sustainable development goals: a health impact assessment of the Trans-Pacific Partnership

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ABSTRACT

The international community, comprised of national governments, multilateral agencies and civil society organisations, has recently negotiated a set of 17 sustainable development goals (SDGs) and 169 targets to replace the Millennium Development Goals, which expired in 2015. For progress in implementing the SDGs, ensuring policy coherence for sustainable development will be essential. We conducted a health impact assessment to identify potential incoherences between contemporary regional trade agreements (RTAs) and nutrition and health-related SDGs. Our findings suggest that obligations in RTAs may conflict with several of the SDGs. Areas of policy incoherence include the spread of unhealthy commodities, threats to equitable access to essential health services, medicines and vaccines, and reduced government regulatory flexibility. Scenarios for future incoherence are identified, with recommendations for how these can be avoided or mitigated. While recognising that governments have multiple policy objectives that may not always be coherent, we contend that states implementing the SDGs must give greater attention to ensure that binding trade agreements do not undermine the achievement of SDG targets.

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Sustainable development goals; trade policy; policy coherence; health impact assessment

Introduction

One of the main outcomes of the Rio+20 Conference in 2012 was agreement by member States to launch a process to develop a set of sustainable development goals (SDGs), which would build upon the Millennium Development Goals, which expired in 2015. Unlike the Millenium goals, the SDGs involved extensive input from national governments, multilateral agencies and civil society organisations, and led to a set of 17 goals and 169 targets. The SDGs are of relevance to everybody concerned with health as they will deeply impact resource allocation in global development programmes. Recognising that the nations responsible for implementing the SDGs often have conflicting domestic policy agendas and priorities, one of the SDG targets (17.14) explicitly references the need to '… enhance policy coherence for sustainable development'. Policy coherence can be defined as the 'absence of incoherences, which occur when other policies deliberately or accidentally impair the effects of development policy or run counter to its intentions' (Ashoff, 2005, p. 1). The United Nations has explicitly singled out trade agreements as a potential source of policy incoherence due to their ability to constrain domestic policy

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space and limit regulatory scope in areas critical for sustainable development (United Nations, 2015). These concerns are not new. Dating back to at least the late 1990s, the World Health Organization (WHO) began engaging with issues of policy coherence across trade and health. Since then, the Oslo-Lancet Commission on Global Governance for Health has highlighted policy coherence (including between trade and health) as a precondition for achieving health equity (Ottersen et al., 2014).

The SDGs are implemented against the backdrop of neoliberal globalisation and the deepening of global trade and investment agreements that embody many of the economic assumptions of neoliberalism. With trade negotiations stalled at the multilateral level, especially inside the World Trade Organization (WTO), regional and bilateral trade agreements have become the preferred means for global trade integration, and the promotion of capital-friendly economic governance arrangements. Although there is consensus amongst mainstream development economists that open economies perform better than closed economies and can generate health-enhancing employment and income benefits (Stevens, Urbach, & Wills, 2013), other development economists have been more critical of these findings (Chang, 2002). Public health scholars have long highlighted the negative effects of neoliberal policies on health and equity (e.g. Global Health Watch, 2014; Schrecker & Bambra, 2015).

Potential incoherences between trade policy and health (Blouin, 2007; Drope & Lencucha, 2014; Friel, Hattersley, & Townsend, 2015; Labonté, Mohindra, & Lencucha, 2011; Walls, Baker, & Smith, 2015), and trade policy and nutrition (Blouin, Chopra, & van der Hoeven, 2009; Friel et al., 2013; Thow et al., 2015) have been discussed in the literature. Evaluations of potential incoherences between trade policy and health and nutrition-related SDGs, however, have so far been absent. In this article, we explore how contemporary regional trade agreements (RTAs) may impair fulfilment of such health and nutrition-related SDGs. Contemporary RTAs have been increasingly scrutinised by health researchers due to their potentially vast health implications and their important role as global standard-setters in the light of the recent failure to reach any multilateral trade agreements (Friel et al., 2013). We focus on three pathways inherent to trade liberalisation that connect contemporary RTAs to health- and nutrition-related SDGs: spread of unhealthy commodities, especially tobacco, alcohol and ultra-processed foods; threats to equitable access to essential health services and affordable medicines and vaccines; and reduced government regulatory flexibility and policy space. We conclude with suggestions for how to address the sources of potential policy conflicts between RTAs and SDGs, and how to manage and mitigate policy incoherences.

Methods: health impact assessment and identification of health-relevant SDGs

This paper draws upon a larger project in which we conducted a health impact assessment of the 12 nation Trans-Pacific Partnership (TPP) agreement, based initially on leaked texts, studies of previously released RTAs and, most recently, on full texts made public after the agreement was signed in early October 2015 (see Figure 1). Health impact assessments are defined as a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population (European Centre for Health Policy, 1999). While there are a range of different analytical approaches to health impact assessment, we used a health impact review methodology which provides a summary estimation of the most significant impacts on health of a broad policy or cluster of policies, such as a comprehensive trade and investment agreement.

We followed the standard protocol for HIAs, which includes a screening, scoping, and appraisal phase, followed by recommendations. During the screening stage we determined which pathways had been identified in the literature linking trade and investment provisions and health outcomes (Friel et al., 2013; Kelsey, 2013; Ruckert, Schram, & Labontè, 2015; Schram, Labontè, & Khatter, 2014; Thow et al., 2015). This review highlighted three key pathways: unhealthy commodities; access to medicines; and regulatory flexibility. Next, we screened the SDGs to identify those health- and nutrition-related SDGs which are most likely to intersect and conflict with RTAs (see Figure 2).

During the scoping stage, we opted for a health impact review methodology. This methodology is suggested when in-depth health impact assessments are not feasible because the policies under

Trade Agreement	Members	% Global GDP	Status
Trans-Pacific Partnership Agreement (TPP)	Australia, Brunei, Canada, Chile, Japan, Malaysia, Mexico, New Zealand, Peru, Singapore, United States, Vietnam	40%	Signed February 2016
Trans-Atlantic Trade and Investment Partnership (TTIP)	European Union, United States	46%	Ongoing negotiations
Comprehensive Economic and Trade Agreement (CETA)	Canada, European Union	26%	Signed in principle

Traditional Chapters	Contemporary Chapters
• Market access	• Investment protection
• Intellectual property rights	• Financial services
• Technical barriers to trade	• Government procurement
• Sanitary and phytosanitary measures	• Regulatory coherence
• Cross-border services	• State-owned enterprises
	• Labour mobility

Figure 1. Defining regional trade agreements.

Notes: Regional trade agreements are defined by the World Trade Organization as reciprocal trade agreements between two or more partners. With the stalling of trade negotiations at the multilateral level, especially inside the WTO itself, RTAs have become the new global standard in trade liberalisation. Contemporary RTAs tend to go far beyond the traditional focus on tariff reduction and facilitation of trade in services, and incorporate a variety of new chapters.

Goal 2. End hunger, achieve food security and improved nutrition, and promote sustainable agriculture
2.1 by 2030 end hunger and ensure access by all people, in particular the poor and people in vulnerable situations including infants, to safe, nutritious and sufficient food all year round
Goal 3. Ensure healthy lives and promote well-being for all at all ages
3.1 by 2030 reduce the global maternal mortality ratio to less than 70 per 100,000 live births
3.2 by 2030 end preventable deaths of newborns and under-five children
3.3 by 2030 end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases
3.4 by 2030 reduce by one-third pre-mature mortality from non-communicable diseases through prevention and treatment, and promote mental health and wellbeing
3.5 strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
3.8 achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all
3.a strengthen implementation of the Framework Convention on Tobacco Control in all countries as appropriate
3.c increase substantially health financing and the recruitment, development and training and retention of the health workforce in developing countries, especially in less developed countries and small-island developing states.

Figure 2. Selected nutrition- and health-related sustainable development goals and targets.

consideration are exceptionally broad, as is the case with RTAs which contain a vast array of trade and investment provisions. The goal of this approach is to create a

> summary estimation of the most significant impacts on health of the policy or cluster of programmes and projects, without necessarily trying to disentangle the precise impact of the various parts of the policy or cluster on specific aspects of health. (European Centre for Health Policy, 1999, p. 7)

During the appraisal stage of the larger TPP health impact assessment, we conducted a realist literature review to generate empirical evidence for our three key pathways of interest. The initial search results returned 6586 articles. Abstracts were reviewed by a team of three individuals for relevancy of the content to development and validation of the pathways. A total of 191 articles were retained, all of which were reviewed and coded by two team members using NVivo 10 software, providing the evidence base for our pathways. For this article, we explored only those findings from our HIA relevant to the SDGs. Finally, we screened the TPP (first leaked, then final and publicly released) chapters for their health-relevant provisions and extrapolated how such provisions might impact SDG-relevant policy areas and conflict with health and nutrition-related SDGs. We have organised the paper so that each of the following appraisal Sections (3, 4 and 5) first presents a pathway linking trade liberalisation to health outcomes, before assessing the extent to which specific trade policies under each pathway might be incoherent with health- and nutrition-related SDGs.

Market access and spread of unhealthy commodities

Since WTO trade agreements have already reduced tariffs substantially amongst member countries, contemporary RTAs, including the TPP, are less likely to focus on further tariff reduction and more on liberalisation of foreign investment, alongside harmonisation of domestic regulations to streamline trade in goods. Various studies show that trade liberalisation can lead to changes in diet and nutrition due to their impact on the structure of food markets. Liberalisation of service sectors and foreign direct investment enables multinational companies to invest in domestic production, processing, retailing and advertising which has led to widespread restructuring of the food production and retail landscape globally, with significant growth in production and distribution of ultra-processed and energy-dense foods (Blouin et al., 2009; Clark, Hawke, Murphy, Hansen-Kuhn, & Wallinga, 2012; Labonté et al., 2011; Stuckler, McKee, Ebrahim, & Basu, 2012; Thow & McGrady, 2014). Prominent examples include Pacific Rim countries and Mexico which have experienced rapid change in diet and an associated rise in obesity rates and other nutrition-related health conditions following rapid foreign direct investment inflows after trade liberalisation (Blouin et al., 2009; Palloni, Beltran-Sanchez, Novak, Pinto, & Wong, 2015).

Trade liberalisation also has the potential to facilitate greater access to and consumption of various harmful substances (Walls et al., 2015). In the case of tobacco, trade liberalisation strongly favours large transnational tobacco companies who invest substantially more resources in marketing and lobbying than local producers (Lee et al., 2009; Lee, Lee, & Holden, 2014), which has led to increased uptake of smoking (Chaloupka & Laixuthai, 1996; Lambert, Sargent, Glantz, & Ling, 2004; Park, Kim, Park, & Lee, 2004; Wen, Cheng, Eriksen, Tsai, & Hsu, 2005). This point is particularly important when considering contemporary RTAs with countries, such as Vietnam, that previously had a closed market actively pursued by transnational tobacco companies (Lee et al., 2008). Similarly, trade liberalisation has been found to lower alcohol prices and lead to increased availability (Zeigler, 2009), and thus has the potential to increase alcohol consumption.

Changes in market structure linked to liberalisation and enhanced market access of transnational companies (TNCs) potentially conflict with achievement of the SDGs in several ways. Market access by TNCs intersects directly with nutrition-related SDG 2 which contains a target (2.1) to 'end hunger and ensure access by all people, in particular the poor and people in vulnerable situations including infants, to safe, nutritious and sufficient food all year round' by 2030. Trade liberalisation can potentially address inadequate food supplies; however, goal 2.1 recognises that not all calories are of equal nutritional value. While trade could potentially contribute to global food security, it is unlikely to do so where it comes at the cost of local production of a diverse array of natural, whole-foods in favour of export-oriented monocultures that deepen import dependency on and consumption of ultra-processed food and unhealthy beverage products (De Schutter, 2011, pp. 14–16; Hawkes, Chopra, Friel, Lang, & Thow, 2007, pp. 60–63). Target 2.1 also specifically identifies the need to protect vulnerable populations, including infants. Market access chapters that reduce tariffs on infant formula may drive

down its cost, while liberalised advertising services may expose new populations of mothers to inappropriate marketing and promotion of commercial baby foods (Smith, Galtry, & Salmon, 2014). If RTAs facilitate misinformation regarding the quality of breast milk and infant formula while reducing costs of formula, they have the potential to undermine both the *World Health Organisation/UNICEF Global Strategy for Infant and Young Child Feeding,* and the nutrition-related SDGs.

Increased market access further has the potential to undermine various health-related SDGs, especially target 3.4 which aims for a reduction by one-third of premature mortality from non-communicable diseases through prevention and treatment. The rise in tobacco, alcohol, and ultra-processed food consumption generally associated with trade liberalisation has the potential to undermine that goal, as well as target 3.5 which specifically aims to prevent harmful use of alcohol.

Threats to equitable access to essential health services and affordable medicines

The principle of progressive liberalisation embedded in treaties necessitates that new RTAs must go beyond commitments in previous agreements, notably those of the WTO, making health services a potential target for further liberalisation. Moreover, service sector commitments in RTAs have moved from the WTO's 'positive listing', wherein the state only liberalises the sectors that are specifically listed, to 'negative listing' wherein the state liberalises everything that is not specifically listed. Incomplete understandings of which services fall within which sectors, or failure to foresee and adequately protect future service configurations, may contribute to the unintentional opening of sectors unsuitable to privatisation, as was the case in countries as diverse as Kenya and Canada, where policy-makers opened the insurance sector without realising it included private health insurance (Sanger & Sinclair, 2004). Privatisation of health services and insurance is generally associated with rising costs and inequitable access to healthcare (Quercioli et al., 2012), with concerns over the potential consequences of privatisation for health equity (Whitehead, Dahlgren, & McIntyre, 2007).

One of the most consistently identified threats to health from RTAs has been their impact on access to medicines (Gleeson, Lopert, & Reid, 2013; Walls et al., 2015). RTAs generally include provisions for the protection of intellectual property, including patents, which go well beyond the WTO agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) (El Said, 2010; Lopert & Gleeson, 2013). Many of these TRIPS+ changes increase the scope of patentability or increase the duration of monopoly protection for new pharmaceuticals, which delays the entry of generic pharmaceuticals into the market, keeping drug prices higher for longer periods. As one example, it has been estimated that the Comprehensive Economic and Trade Agreement between Canada and the EU will cost the Canadian public healthcare system an additional CAD850 million – CAD1.6 billion annually without providing any new therapeutic benefit (Lexchin & Gagnon, 2013). The cost of provisions for biologic medicines in the TPP to the Australian healthcare system may amount to hundreds of millions of dollars annually if they are implemented in a way that prolongs market exclusivity (Hirono, Haigh, Gleeson, Harris, & Thow, 2015). Recent US trade agreements have also included provisions targeted at the procedures of pharmaceutical pricing and reimbursement programmes. Depending on how these are drafted and implemented, they could reduce the ability of governments to contain costs (Gleeson et al., 2013; Lopert & Gleeson, 2013), and there are concerns that similar stipulations will be included in future RTAs (Gleeson, 2015).

The achievement of several health targets including the reduction of global maternal mortality ratios (3.1), under-five mortality rates (3.2), and infection from AIDS, tuberculosis, malaria and other communicable diseases (3.3) will strongly depend on access to quality essential healthcare services, affordable essential medicines and vaccines, and retention of a skilled health workforce, particularly in developing countries. Continued privatisation of health services and the protection of patent rights over patient rights, both of which remain on trade treaty agendas, are likely to undermine all of these health-related SDGs and the international community's commitment to achieve universal health coverage for all.

Reductions in government regulatory flexibility

Another concern consistently expressed by those at the nexus of trade and public health has been the potential for provisions in RTAs to encroach upon state sovereignty over domestic policy-making to a greater extent than the flexibilities still permitted within WTO agreements. Chapters pertaining to *technical barriers to trade*, for example, require new regulations to be *least trade restrictive* and considerable evidence or justification if they exceed internationally agreed upon standards. Although this is the case with the WTO agreement on technical barriers, newer RTAs often propose more stringent requirements. The TPP, for example, includes a regulatory coherence chapter that imposes new obligations on governments in the development and reporting of regulations, offering new opportunities for private sector involvement and policy capture (Kelsey, 2011).

While these and other provisions in RTAs involve trade policy that increasingly creeps into traditionally domestic domains and other policy spheres, it is the enforcement measures that have many in public health particularly concerned. Mechanisms for investor–state dispute settlement (ISDS) give private investors the means to litigate against the state in situations where an investment is perceived as having been devalued by a government measure, even regulations made in good faith. While these international tribunals cannot demand that a state overturn its regulations, arguably respecting a state's right to regulate, they can assign large sums of money in compensation to the foreign investor, creating a new divide between states that can and cannot afford to regulate. The transparency and accountability of ISDS tribunals have also been called into question (Olivet & Eberhardt, 2012). Even in cases where governments win these disputes, the process takes years and costs millions of dollars in legal fees, making it particularly difficult for developing countries to disregard the threat of ISDS when introducing new policies and regulations (Brown, 2013).

Such provisions in RTAs can reduce the policy space and regulatory flexibility required to implement the SDGs. As one example, the SDGs aim to strengthen the implementation of the Framework Convention on Tobacco Control (Target 3a). While plain packaging has been encouraged in the Guidelines for the Implementation of article 13 of the FCTC (2009), Australia and Uruguay's recent attempts to implement this have been met with legal action through ISDS provisions (Jarman, 2013; McGrady, 2011). These cases went forward despite the fact that plain packaging is widely considered by legal experts to be compatible with current international IP standards as set out in the TRIPS (Marsoof, 2013; Mercurio, 2012; Voon & Mitchell, 2011). Countries interested in plain packaging, such as New Zealand, had explicitly stated they would wait for the outcome of the Australian challenge before moving forward, delaying positive outcomes from such smoking cessation efforts by years[1] (Crosbie & Glantz, 2014; Daube, Moodie, & Chapman, 2012; Lin, 2013). Similarly, in the case of alcohol, Ashe, Jernigan, Kline, & Galaz (2003) highlight the importance of governments retaining 'police powers' to regulate and attach conditions to land use, such as number and placement of alcohol retail outlets to reduce consumption. Attempts to introduce new regulations pertaining to where and when alcohol can be sold or restrictions on advertising may give foreign alcohol companies, with a demonstrated investment in the host state, grounds to initiate litigation against the state for altering the investment climate. A TPP annex for wine and spirits intended to harmonise labelling requirements allows alcohol exporters to meet the labelling requirements of importing countries by the addition of a supplementary label; this may present a barrier to the introduction of optimal health warning systems on alcohol containers in future (O'Brien & Gleeson, 2013).

Target 2.1 identifies the need to focus on the poor in food security strategies. A number of studies from Australia, Canada, New Zealand and the United States have highlighted the relationship between neighbourhood deprivation and fast food outlet density (Block, Scribner, & DeSalvo, 2004; Pearce, Hiscock, Blakely, & Witten, 2009; Redpaith, Burns, Gerrard, Mahoney, & Townsend, 2002; Smoyer-Tomic, Spence, Raine, & Healy, 2008) and advertising for unhealthy food products (Lewis, Sloane, Nascimento, & Flynn, 2005). Implementation of new domestic regulation to address these inequities, such as restrictions on outlet density or targeted advertising of unhealthy products to low SES populations, could elicit an investment challenge from foreign food companies using ISDS mechanisms available to them in

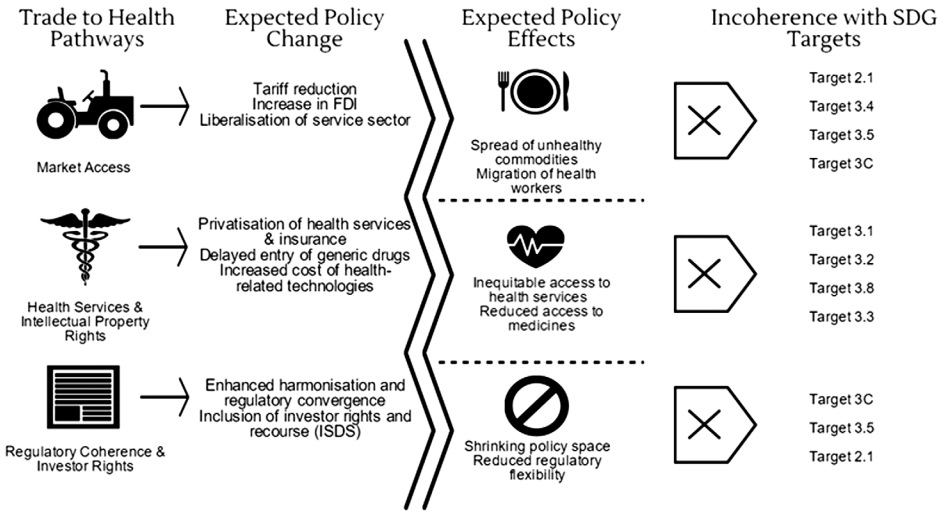

Figure 3. Conceptual framework for policy coherence analysis.

RTAs; specifically, their right to fair and equitable treatment, the most relied upon and successful basis for ISDS challenges (UNCTAD, 2009) utilised when there has been a change in domestic regulation affecting the investment climate. Uncertainty as to how an ISDS tribunal might rule on fair and equitable treatment and fear of the associated expenses may lead to regulatory chill and thus may deter effective policy approaches to achieving the nutrition-related SDGs (Figure 3).

Policy implications and suggestions

One of the central flaws of the negotiation process surrounding contemporary RTAs, and the TPP is no exception, is the absence of transparency and public input into the negotiation of trade agreements (Otterson et al., 2014, p. 643). Given the reach of many of the provisions and measures codified in RTAs, there is clearly a need for reforming and improving the negotiation process. In order to ensure policy coherence, or, at a minimum, mitigate incoherence, health experts must have a seat at the table and health impact analyses should be used to inform trade negotiations. However, there are a number of specific safeguards that, if included in all RTAs, could allow for improved management of potential incoherences with the SDGs.

Strong civil society and academic critiques of ISDS have recently led to greater caution about how these mechanisms are included within new trade treaties. Concerns with the ISDS clause in the Trans-Atlantic Trade and Investment Partnership led to the passing of a compromise amendment by the European Parliament that calls for replacing the ISDS system

> with a new system … subject to democratic principles and scrutiny, where potential cases are treated in a transparent manner by publicly appointed, independent professional judges in public hearings and which includes an appellate mechanism, where … the jurisdiction of courts of the EU and of the member states is respected, and where *private interests cannot undermine public policy objectives*. (Bridges Weekly, 2015, p. 5, emphasis added)

However, even the EU amendment does not appear to address many of the critics' concerns with ISDS, as neither the proposed procedure for the appointment of judges in the new court system nor their position meet the international requirements for the independence of courts. In addition, it is unclear why such investment protections are needed at all in countries with effective legal systems.

However, if the international community were to decide to continue inclusion of ISDS in trade treaties, then we need to ensure a fair, multilateral system in which corporate and public interests are balanced more effectively. India's 'model' bilateral investment treaty goes some way towards such a balance, as

it includes relatively strong exceptions for non-discriminatory regulatory measures to protect public interest objectives, including health and the environment. A complete removal of health from the realm of ISDS disputes, especially if clearly defined as exclusions from any ISDS provisions, would best protect policy space in trade agreements. To address concerns about litigation of tobacco companies, specific tobacco carve-outs should be included in all trade agreements. Some countries have taken such a position during RTA negotiations. For example, Malaysia maintained that a carve-out would be necessary to protect the governments' ability to enact measures contained in the WHO Framework Convention of Tobacco Control.[2]

Similarly, in order to ensure access to medications for vulnerable populations, some TPP member states were reportedly opposed to US efforts to further extend intellectual property rights (Cheong, 2013). Given the relevance of access to medicines and vaccines for achieving a range of health-related SDGs, any protection of intellectual property rights in pharmaceuticals should be limited to those already present in the WTO's TRIPS agreement, which in effect means, at a minimum, excluding any expanded or extended monopoly protections for drugs, biologics or other health-related technologies in new RTAs beyond those in TRIPS. As we now know, this was not case with the TPP, and will likely be one of many public health and civil society pressure points in their efforts to prevent ratification of the agreement in its present form.

Exclusion of health services and insurance (or other public goods) from trade agreements represents another important consideration for reducing potential conflicts between RTAs and SDGs, and is widely recognised as a reasonable way to protect the public provision of health services, including in recent negotiations of the Trans-Atlantic Trade and Investment Partnership where draft texts include language that suggests that health services will be excluded. Additional attention should be paid to health insurance, which is liberalised through the insurance subsector in a services chapter, as opposed to the health services subsector, and consequently may not be subject to any such health exceptions. Fully excluding certain service sectors from trade agreements does not mean that private, commercial trade (including foreign direct investment) is prohibited. It merely means that governments are less likely to be challenged in a trade or investment dispute based on those commitments should they choose to return privatised services to public provision, if needed or desired. Finally, RTA negotiations should follow the WTO's General Agreement on Trade in Services and use a positive listing approach, as was reportedly preferred by Vietnam in TPP negotiations (Cheong, 2013). Positive listing lowers the likelihood of countries accidentally opening up sectors to liberalisation.

Conclusion

Our health impact assessment indicates that there is clear evidence that current trade and investment policy comes into tension, and in some cases directly conflict, with the SDGs. Although it is unlikely that all incoherences between policies in competing sectors can be eliminated, the managed reduction of potential policy incoherences will be essential to the global effort to achieve the SDGs. We have illustrated several policy scenarios through which health- and nutrition-related SDGs may be undermined by new RTA provisions, and how this can be mitigated within the treaty-making processes and through specific provisions (or their exclusion). However, even if governments are keen to ensure better coherence between health and trade policy spheres, technical policy analysis will not suffice to do so. As trade negotiations have migrated from the multilateral to the regional and bilateral level, multinational corporations have played an increasingly influential role and succeeded in lobbying for inclusion of highly contested provisions that benefit them directly. This political nature of trade negotiations, with many corporations also involved in closed-door consultations during TPP development, means that future trade negotiations must recognise, and attempt to limit, influence from special (corporate) interests to allow for the emergence of health-sensitive trade policy. This will be no easy task as power imbalances inherent to trade negotiations ultimately reflect the wider (and still growing) imbalances in the global economy since the rise of neoliberalism in the early 1980s, characterised by an increasingly

inequitable distribution of resources combined with emphasis on market mechanisms and individual responsibility (Walls et al., 2015).

So what does this mean for the broader field of critical public health? Achieving more health-sensitive trade policy requires increased recognition of corporate influence in trade negotiations and more salient efforts by health activists to counterbalance such influence. But better policy coherence also depends on establishing institutional structures that help bridge existing sectoral gaps and overcome ideological divergences between the health and trade communities. However, it is important to emphasise that neoliberal trade treaties are just one policy by which the SDGs could be derailed. Ultimately, there are many other elements of the neoliberal policy regime which might come into conflict with achievement of SDGs. This will ultimately require a much better coordinated global governance (for health) system in which health concerns become a cross-sectoral political concern and inform decision-making processes in key sectors of the economy, including trade negotiations. Given the growing awareness of the relevance of trade agreements and other neoliberal global governance mechanisms to health, critical public health scholars must more systematically research these links and engage with and seek meaningful input into trade discussions at the bilateral, regional and multilateral level.

Notes

1. In December 2015, the *Philip Morris v Australia* case was dismissed on jurisdiction, rather than on the merits of the case, leaving the policy legitimacy of tobacco plain packaging within international investment arbitration unresolved for the time being.
2. The final text of the TPP included a carve-out for tobacco control measures from ISDS. This exception does not protect measures from state–state dispute settlement procedures, nor does it protect ISDS cases regarding tobacco control measures arising from previously negotiated RTAs without equivalent protections, e.g. the North American Free Trade Agreement.

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