WOMEN'S BUDGET GROUP

BRIEFING

Trade and Health:
A gender analysis

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2022

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Executive Summary

This briefing, written for the Women's Budget Group by Silke Trommer, University of Manchester, examines through a feminist lens how the UK's trade policy agenda intersects with public health. The links between trade and health are feminist issues, because women are primarily responsible for care and life-making work in the formal economy and in domestic settings. The briefing examines how the UK-Japan, UK-Australia and UK-New Zealand Free Trade Agreements (FTA) affect health systems and food & nutrition, which are central to good health and social reproductive conditions for all. The UK government's current approach to trade negotiations fails to tackle known problems around the trade and health nexus, including its gendered dimensions, thus upholding gendered, health and other social inequalities.

- The government is limiting domestic policy space for the production and consumption of healthy foods and is moving away from EU and WTO rules that confirm the precautionary principle on consumer safety.
- It subscribes to Intellectual Property provisions in FTAs that go beyond WTO rules and tilt the political and regulatory balance between public and investor interests further in the direction of investors.
- It takes an extensive approach to service liberalisation, liberalising most service sectors implicated in the day-to-day running of the NHS and social care.
- Although a number of health services are explicitly exempt in UK-New Zealand, and all three agreements allow governments to regulate in the interest of health in principle, the relevant provisions do not provide sufficient legal certainty to effectively safeguard policy space on health and care services for future UK governments.
- The government procurement chapters in UK-Australia and UK-New Zealand set a welcome precedent by including a clause on environmental, social and labour considerations, although this should not be subject to non-discrimination requirements and should be broadened in scope to explicitly include health and gender.
- While Investor-State Dispute Settlement is currently excluded in all three FTAs, it is not clear that UK negotiators will exclude it in attempts to join the Comprehensive and Progressive Agreement for Trans-Pacific Partnership or in negotiations with Canada, the US, Mexico or India.

Policy recommendations for UK trade agreements on health systems and food & nutrition:

- Apply gender-based and health-based impact assessments and monitoring and remedy negative impacts of trade agreements on gendered, health, and other social inequalities.
- Include a wide range of civil society actors in trade policy decision-making, including those representing public health, food safety and food security, and gender equality concerns.
- Take implications for UK food environments and dietary habits into account when negotiating agricultural liberalisation commitments.
- Reaffirm subsidy and safeguard provisions under the WTO Agreement on Agriculture.
- Under regulatory standards explicitly allow going beyond international standards, remove least trade restrictive requirement for measures meeting the public policy goal, enshrine the precautionary principle, and close special access routes for vested interests or include all societal stakeholder groups.
- Remove provisions in intellectual property chapters that go beyond WTO obligations.
- Exclude the NHS explicitly and fully from trade agreements.
- Adopt positive-list approach to service liberalisation and exclude service sectors relevant for the day-to-day running of the health system, expanding on or at a minimum following the UK exclusions in the New Zealand deal.
- Take employment conditions in health system and domestic care settings into account when negotiating service liberalisation commitments.
- Remove least trade restrictive condition for public health exceptions and allow measures to be taken where they are "relating" to, not "necessary" for public health.
- Do not include clauses binding future policies (including so-called "third-party MFN" and "ratchet" clauses) unless there are effective public health carve-outs.
- Adopt UK-Australia and UK-New Zealand approach to Government Procurement, adding "public health outcomes" to the list, making clear that "social outcomes" may include gendered and other social inequalities, and removing the non-discrimination requirement for these carve-outs.
- Adopt the UK-New Zealand model on investor-state dispute settlement, carving it out entirely and setting "genuine economic link" requirements for accessing benefits, or at a minimum explicitly exclude investor-state dispute settlement in the domain of public health and gender equality.

1. Introduction

The Covid-19 pandemic exposes the ambivalent links between trade and health. Trade helps producing welfare, knowledge and technology,[1] which can support health, but also acts as a vector for disease transmission and social and economic inequalities, which give rise to poor health.[2] Covid-19 has destabilised global trade flows in 2020[3] and 2021,[4] which has provoked crises in 'supplies of drugs and medical equipment, nutrition and food security, and government income necessary to pay for health services'[5].

While observers argue that in the Covid era, health must constitute a priority for trade policymaking,[6] few explicitly take a feminist stance. This briefing outlines why the links between trade and health are feminist issues. It discusses how trade agreements affect health systems, and food & nutrition, which are two areas that are central to good health and social reproductive conditions for all. It examines the new UK-Japan Comprehensive Economic Partnership, and the UK-Australia and UK-New Zealand Free Trade Agreements (FTA). It argues that the UK government's current approach to post-Brexit trade negotiations fails to tackle known problems around the trade and health nexus, including its gendered dimensions, thus upholding gendered, health and other social inequalities in the UK. The briefing closes with a set of policy recommendations for UK trade policymaking on health systems and food & nutrition that could help using trade as a lever for reducing these inequalities in the UK and elsewhere.

1 Feachem, R. (2001) "Globalization is good for your health, mostly", British Medical Journal 323 (7331), 504-506.

2 Woodward, D. et al (2002) "Globalization, Global Public Goods, and Health", in Drager, N. and C. Vieira (eds.) *Trade in Health Services: Global, Regional and Country Perspectives*, Washington, D.C.: Pan-American Health Organization, pp. 3-11.

3 Baldwin, R. (2020) The Greater Trade Collapse of 2020: Learnings from the 2008-09 Great Trade Collapse, VoxEU, 7 April 2020.

4 Farrer, M. (2021) 'A Perfect Storm': Supply Chain Crisis Could Blow World Economy off Course, The Guardian, 2 October 2021.

5 Barlow, P. et al (2021) "COVID-19 and the Collapse of Global Trade: Building an Effective Public Health Response", *The Lancet Planetary Health*, 5(2), e102-e107.

6 Van Schalkwyk, M. et al (2021) "Brexit and Trade Policy: An Analysis of the Governance of UK Trade Policy and What it Means for Health and Social Justice", *Globalization and Health*, 17(1), 1-18.

2. Trade and health: A feminist issue

Social reproduction is a useful analytical concept to consider the links between trade and health from a feminist standpoint. Social reproductive work includes care work for children, the sick and the elderly, food provisioning, and other domestic and household chores necessary for daily life. Social reproduction aims to achieve or maintain health,[7] but can be carried out under conditions that undermine health.[8] Social reproductive work is generally unpaid or underpaid, and, where it takes place in domestic spheres, it is not seen as forming part of "the economy",[9] despite being essential for the productive economy to exist and function.

Trade policymakers generally regulate trade based on the gendered view that transnational flows of goods, services, money and knowledge primarily affect the productive economy.[10] Trade agreements typically make liberalisation commitments in goods and services trade and directly regulate trade-related areas, such as product and safety standards, intellectual property (IP) or investment, based on the idea that increased economic competition within the productive economy maximises the welfare of society. Seen through a growth-focused, productive economy lens, the health effects of trade policy[11] and the gendered impacts of trade[12] appear as second-order issues in trade policymaking. Trade agreements typically include general exceptions and dedicate clauses or chapters to broader societal issues, such as health, gender, labour, the environment, etc., in order to balance the effects of standard commercial commitments on ostensibly "wider" areas of public policy.

However, the orthodox view of trade as centred within the productive economy alone does not stand up to feminist scrutiny.[13] Standard commercial commitments in trade agreements directly affect the global distribution of medical products, nutrition and food safety, health services, and a clean environment,[14] all of which impact on human health and social reproductive labour. Trade agreements therefore directly affect health and social reproduction, although in complex and differential ways. As becomes apparent below, trade agreements in their current form support good health and social reproductive conditions for some populations, but undermine these conditions for other populations.[15]

7 Elson, Diane (2012) "Social Reproduction in the Global Crisis: Rapid Recovery or Long-Lasting Depletion?", in Utting, P. et al (eds.) *The Global Crisis and Transformative Social Change*, London: Palgrave Macmillan, pp. 63-80.

8 Doyal, L. (1995) *What Makes Women Sick: Gender and the Political Economy of Health*, Basingstoke: Macmillan.

9 Bakker, I. (2007) "Social Reproduction and the Constitution of a Gendered Political Economy", *New Political Economy*, 12(4), 541-556.

10 Hannah, E. et al (2021), "Gender in Global Trade: Transforming or Reproducing Trade Orthodoxy?", *Review of International Political Economy*, doi.org/10.1080/09692290.2021.1915846.

11 Barlow, P. et al (2021) "COVID-19 and the Collapse of Global Trade: Building an Effective Public Health Response", *The Lancet Planetary Health*, 5(2), e102-e107.

12 Hannah, E. et al (2018), Gendering Global Trade through Canada-UK Trade Relations, 30 November 2018.

13 Trommer, S. (2021) "Trade, Health and Social Reproduction in a COVID World", *Globalizations*, doi.org/10.1080/14747731.2021.1964746.

14 Barlow, P. et al (2021) "COVID-19 and the Collapse of Global Trade: Building an Effective Public Health Response", *The Lancet Planetary Health*, 5(2), e102-e107.

15 Trommer, S. (2021) "Trade, Health and Social Reproduction in a COVID World", *Globalizations*, doi.org/10.1080/14747731.2021.1964746.

This is a feminist issue because women continue to be the primary providers of social reproductive work across the productive economy and domestically. Feminist trade research furthermore suggests that women and other vulnerable groups tend to lack the economic, social and political resources to absorb trade shocks,[16] and therefore tend to be disproportionately represented among those populations whose health and social reproductive conditions are undermined by trade agreements. The feminist view that social reproductive work is the essential work of society[17] implies that the links between trade, health and social reproduction are central trade issues, and not second-order, trade-related issues.

Box 1 provides an overview of how standard commitments in trade agreements interact with health systems and with food & nutrition. These links and their gendered dimensions are analysed in the following sections.

Box 1: Links of standard commitments in trade agreement to health systems and food & nutrition

Standard commitments in trade agreements	Health systems	Food & nutrition
Trade in goods liberalisation	affects the availability and affordability of medical products including medicines and medical equipment.	affects the availability and affordability of healthy and unhealthy foods and other harmful substances such as tobacco, alcohol and sugar.
Regulatory standards (notably Sanitary and Phytosanitary Measures (SPS) and Technical Barriers to Trade (TBT))	affect the government's ability to restrict trade flows based on product standard considerations.	affect the government's ability to restrict trade flows based on food standards considerations, to act on scientific uncertainty, and to regulate in favour of healthy food & nutrition (including labelling).
Intellectual property rights	in pharmaceuticals, affect the accessibility and affordability of medical products including medicines and medical equipment.	in food and biotechnology, affect the accessibility and affordability of healthy and unhealthy foods.
Trade in services liberalisation	affects the government's ability to regulate all aspects of the healthcare sector. Potentially affects cost containment in health care when liberalisation does not lower costs.	affects the government's ability to regulate the distribution and advertising services of healthy and unhealthy foods and other harmful substances such as tobacco, alcohol and sugar.
Government procurement	affects the government's ability to provision for the healthcare sector.	affects terms and practices for procurement of goods for the public sector.
Investment protection	requires government to comply with set principles and measures in the agreement as they relate to treatment of foreign investors.	

16 Hannah, E. et al (2021), "Gender in Global Trade: Transforming or Reproducing Trade Orthodoxy?", *Review of International Political Economy*, doi.org/10.1080/09692290.2021.1915846.

17 Jaffe, S. (2020) "Social Reproduction and the Pandemic, with Tithi Bhattacharya", *Dissent*, 2 April 2020.

Like many trade bureaucracies, the UK's Department for International Trade (DIT) engages in stakeholder consultations and conducts impact assessments of prospective trade agreements, which need to be signed, ratified, implemented and monitored. Whose concerns are heard across the policy cycle, and what types of concerns are commonly understood to be essential trade issues has implications for the effects of a trade agreement on health and social reproduction.

Effective gender-based impact assessment and, importantly, also monitoring of trade agreements should ensure that trade policies do no gendered harm, and that unintentional negative consequences can be remedied.[18] Under food and nutrition[19] and health systems,[20] effective impact assessment and monitoring should identify relevant clauses in trade agreements,[21] and make sure that policy space for health regulation is maintained or expanded upon. To make these types of progressive trade policy practices effective, trade bureaucracies should take an inclusive approach to policymaking,[22] whereby the positions of women's groups, gender experts, health experts, food poverty groups, and many more societal groups are taken into account when trade agreements are negotiated.

18 Hannah, E. (2019) Gender and Trade: Briefing from the Women's Budget Group on the Impact on Women of International Trade and Investment Agreements, London: Women's Budget Group.

19 Friel, S. et al. (2013) "Monitoring the Impacts of Trade Agreements on Food Environments", *Obesity Reviews*, 14, 120-134.

20 Koivusalo, M. (2014) "Policy Space for Health and Trade and Investment Agreements", *Health Promotion International*, 29(1), 29-47.

21 Smith, R. et al (2009), "Trade and Health: An Agenda for Action", *The Lancet*, 373(9665), 768-773.

22 Hannah, E. (2019) Gender and Trade: Briefing from the Women's Budget Group on the Impact on Women of International Trade and Investment Agreements, London: Women's Budget Group.

3. UK trade policy initiatives

The Covid-19 pandemic coincides with Brexit, which has led the UK government to re-negotiate its global trade relations. Following a period of rolling over WTO commitments and former EU trade agreements, the UK government began engaging in its first independent FTA negotiations. It signed an FTA with Japan on 23 October 2020 that entered into force on 1 January 2021.[23] The Japan FTA is a roll-over agreement of the EU-Japan FTA, but also contains new provisions, such as a gender chapter. The UK has also signed FTAs with Australia on 16 December 2021[24] and with New Zealand on 28 February 2022,[25] that are passing through the ratification process at the time of writing. It is further negotiating with the US, Canada, Mexico and India,[26] as well as hoping to join the Comprehensive and Progressive Agreement for Trans-Pacific Partnership (CP-TPP).[27]

Given this context, the UK is uniquely placed to exert global leadership on trade and health by tackling existing problems,[28] including how the links between trade and health affect women and other vulnerable populations. All three FTAs contain a gender chapter (Chapter 21 UK-Japan FTA, Chapter 24 UK-Australia FTA, Chapter 25 UK-New Zealand FTA), as well as gender-related provisions across other chapters. Broadly speaking, the gender chapters aim to harness trade to advance 'gender equality' and 'inclusive growth', reaffirm WTO-based gender and trade initiatives[29] and establish cooperation mechanisms for sharing best practices on gender sensitive trade policy and evidence-based policymaking.

These principles notwithstanding, a closer analysis of how commitments in the three legal texts interact with health systems and food & nutrition reveals that UK trade policymakers risk reproducing existing issues around trade, health and social reproduction and are falling short of best practices that could benefit good health and social reproductive conditions for all.

3.1 Food and Agricultural products

Trade in goods liberalisation, that is to say, the removal of tariffs and quotas on imported products and the removal of state supports for exported products, can have welfare-enhancing effects by increasing the accessibility, availability and affordability of liberalised products. In food & nutrition in particular, governments typically take trade liberalisation commitments with

23 HM Government (2020) UK/Japan: Agreement for a Comprehensive Economic Partnership.

24 HM Government (2021) Free Trade Agreement between the United Kingdom of Great Britain and Northern Ireland and Australia - GOV.UK (www.gov.uk)

25 HM Government (2022) Free Trade Agreement between the United Kingdom of Great Britain and Northern Ireland and New Zealand - GOV.UK (www.gov.uk)

26 HM Government (2020) The UK's Trade Agreements.

27 Department for International Trade (2021) UK Accession to CPTPP: The UK's Strategic Approach, London: DIT.

28 Van Schalkwyk, M. et al (2021) "Brexit and Trade Policy: An Analysis of the Governance of UK Trade Policy and What it Means for Health and Social Justice", *Globalization and Health*, 17(1), 1-18.

29 For a recent summary of WTO gender initiatives see Hannah, Erin and Silke Trommer (2022) The WTO's Gendered Comeback: Gender Concerns at the 12th Ministerial Conference

the facilitation of Foreign Direct Investment, international competition in food production and food supply, consumer purchasing power, and consumer choice in mind.

Trade liberalisation in food & nutrition can have positive impacts on health and social reproductive conditions, because it can support food security, particularly for marginalised populations. This is principally because trade liberalisation typically leads to reduced consumer costs. However, cost of food is only one dimension of how trade liberalisation interacts with health and social reproduction. To assess the impacts of trade liberalisation on health and social reproductive conditions, much also depends on what types of products become most accessible and/or affordable for consumers following the implementation of a trade agreement. At present, trade liberalisation commitments on food & nutrition tend to benefit agribusiness and transnational food industries,[30] which predominantly supply unhealthy and highly processed foods and their ingredients (e.g. soft drinks, snacks, baked and frozen goods, fast foods, ready meals, processed meats, processed dairy and corn and sugar-based sweeteners). Liberalisation commitments tend to economically disadvantage local and small-scale food producers, which tend to supply healthier and less- or non-processed foods.

Where trade agreements liberalise meat, dairy and highly processed foods and such produce outcompetes local and/or healthier foods on price, they can change food environments and dietary habits in ways that have a negative impact on health.[31] Where this occurs, households holding less spending power, in which women and other vulnerable groups are disproportionately represented, are less able to make healthy food choices than wealthier households. These effects can be compounded where commitments in trade agreements remove agricultural safeguards and subsidies, which have trade distorting effects, but can shield local and small-scale producers from international competition.

The UK-Japan, UK-Australia and UK-New Zealand FTAs reproduce the differential ways in which trade liberalisation in agricultural products interacts with the health and social reproductive conditions of different social groups. UK-Japan phases out existing agricultural trade barriers in pork, beef, grain, dairy, alcoholic beverages, and a range of highly processed foods (UK-Japan FTA Annex 2). UK-Australia liberalises beef, sheep, dairy products, wheat, barley, rice as well as sugar cane over a 10–15-year period (UK-Australia FTA Annex 2). The UK-New Zealand commits the UK to liberalising imports of beef and sheep meat, dairy, wine, fresh apples, and certain processed meats over a 5-15-year period (UK-New Zealand FTA Annex 2). All three texts in essence reaffirm the WTO Agreements on anti-dumping, anti-subsidy and safeguards, including specific safeguards provided for in the WTO Agreement on Agriculture, where special sets of rules apply to state support for agricultural production.

While UK meat and dairy producers[32] and devolved governments[33] are concerned about commitments with Australia and New Zealand in particular, it is unlikely that the FTAs alone will significantly affect food environments and dietary habits in the UK. Nonetheless, this may change as the UK negotiates with other countries that have strong offensive trade interests in

30 Hawkes, C. (2007) Globalization and the Nutrition Transition: A Case Study, Case Study 10-1 of the Program "Food Policy for Developing Countries: The Role of Government in the Global Food System", Cornell University.

31 Friel, S. et al. (2013) "Monitoring the Impacts of Trade Agreements on Food Environments", *Obesity Reviews*, 14, 120-134.

32 Clarke, P. (2021) New Zealand Delight at Trade Deal Contrasts with UK Farmer Dismay, Farmers Weekly, 21 October 2021.

33 Campbell, J. (2021) Brexit: UK-New Zealand Trade Deal criticised by Edwin Poots, BBC News, 2 November 2021.

meat, dairy, highly processed and other unhealthy foods. In this respect, the UK-Japan FTA is noteworthy, as it contains a standalone chapter that commits governments to promoting trade in agriculture, exchanging information on sustainable agriculture, cooperating on technology, and improving the "business environment" for food and agricultural producers (Chapter 19 UK-Japan FTA). From a health and social reproductive standpoint, a key concern is that such cooperation will consolidate the market power of large food and agricultural corporations, while those unable to afford healthy food choices will disproportionately pay associated health costs. As things stand, the various texts with Japan, Australia and New Zealand suggest that the UK government is set to replicate known problems with the impacts of agricultural liberalisation on food environments when it comes to health, including their gendered dimensions.

3.2 Regulatory standards

Regulatory standards in trade agreements - anchored for the most part within rules on Sanitary and Phytosanitary (SPS) Measures and Technical Barriers to Trade (TBT) - condition the government's ability to restrict trade flows based on health and safety considerations. In principle, SPS and TBT rules allow for a balancing exercise between consumer safety and human, animal and plant life and health on the one hand, and the free flow of international trade, on the other hand.

However, existing SPS and TBT rules tend to be biased in favour of trade flows. Food and agricultural safety rules under SPS provisions, for example, can prevent governments from seeking health protections, lack minimum health standards, and lack clarity on the use of scientific knowledge and product labelling when balancing health and trade concerns.[34] TBT provisions can limit the government's ability to use food marketing rules and labelling to guide consumers towards healthy food choices.[35] One key question is whether FTAs explicitly allow higher consumer safety standards than those that international standards require. The standing of scientific uncertainty when governments take trade restrictive measures in the interest of consumer safety (see Box 2) is another key concern. Like under goods liberalisation, the poorest households, in which women and other vulnerable populations are disproportionately represented, rely more on the government's ability to enforce the highest consumer safety standards and to structure markets in favour of safe and high quality products.

34 Charnovitz, S. (2000) "The Supervision of Health and Biosafety Regulation by World Trade Rules", *Tulane Environmental Law Journal*, 13(2), 271-302.

35 Friel, S. et al. (2013) "Monitoring the Impacts of Trade Agreements on Food Environments", *Obesity Reviews*, 14, 120-134.

Box 2: SPS and Scientific Uncertainty

Standard SPS provisions in trade agreements oblige governments to base trade restrictive measures in the name of product safety and consumer protection on a risk assessment. Much controversy has ensued around what constitutes a risk assessment and under what conditions the results of a risk assessment can justify a trade restrictive measure. The issue of whether governments can restrict trade in the face of scientific uncertainty (e.g. when different studies indicate different levels of risk, or scientific experts differ in their assessment of the safety of a specific product or process or production method) has been particularly thorny. The European Union has been the primary international proponent of the so-called precautionary principle, which condones trade restrictive measures in the face of scientific uncertainty. The United States, Canada and other countries are proponents of a reactionary approach, whereby risk has to be scientifically established in order for a trade restrictive measure to be justified. This difference in approach to scientific uncertainty around consumer protection remains unresolved in international trade relations to date.

When it comes to new UK trade agreements, there are variations in SPS and TBT commitments, although, on balance, all three FTAs tend to deepen rather than address pro-trade bias. On SPS and TBT, the UK-Japan and UK-New Zealand FTAs condition governments to take the least trade restrictive measures to assure product and consumer safety (Art 6.1(a) and Art 7.1(a) UK-Japan FTA, Art 5.8.2(b) UK-New Zealand FTA), rather than being able to take any measure that may prove effective to attend the policy goal. UK-Australia and UK-New Zealand aim to ensure that measures "do not create unjustified barriers to trade" (Art 6.2 UK-Australia FTA, Art 5.3 UK-New Zealand FTA).

None of the three texts explicitly allows going beyond international standards on product safety, although UK-New Zealand encourages parties to cooperate internationally to develop standards, guidelines and recommendations on human, animal, and plant life and health (Art 5.3 UK-New Zealand FTA). Where parties use standards that differ from international standards, there is an obligation in UK-Japan to explain why such diverging standards were taken, including the scientific and technical evidence on which such reasoning was based (Art 7.3(b) UK-Japan FTA). This creates bureaucratic hurdles for deviating from international product and consumer safety standards.

While the UK-Japan and UK-New Zealand FTAs confirm the WTO SPS Agreement and its procedures on risk assessment (Art 6.6 UK-Japan FTA, Art 5.8 UK-New Zealand FTA), the UK-Australia FTA stipulates that "SPS measures are based on scientific principles" (Art 6.5 UK-Australia FTA). This is more restrictive than the WTO approach, which "has a holistic understanding of science and specifically incorporates the precautionary principle".[36] Given that the UK is also negotiating with the US and Canada, and is hoping to join the CP-TPP,[37] which all apply a reactionary approach to risk assessment in product and consumer safety, the evidence suggests that the UK government is gradually moving away from the EU's precautionary principle via its trade agenda.

36 Trade and Public Policy Network (2022) What is in the UK-Australia FTA? Preliminary Reflections.

37 Labonté, R. et al (2016) "The Trans-Pacific Partnership: Is It Everything We Feared for Health?", *International Journal of Health and Policy Management*, 5(8), 487-496.

Under TBT, UK-Japan and UK-Australia make domestic labelling rules subject to least trade restrictive requirements, which may stifle government innovation in progressive product labelling[38] around unhealthy or unsafe products (Art 7.11 UK-Japan FTA, Art 7.8 UK-Australia FTA). The agreements may further provide vested interests access to standard setting, in particular when "persons of the other Party" (Art 7.9.1(b) UK-Japan FTA, Art 7.9 UK-Australia FTA, Art 7.9 UK-New Zealand FTA) are given access to consultation procedures around technical regulations and conformity assessments. On balance, the regulatory standards enshrined in the three FTAs raise concerns that UK trade policy will serve transnational investor and corporate interests, rather than using trade as a lever to assure the highest standards of product and consumer safety for all societal groups.

3.3 IP Protection

Intellectual Property (IP) protection clauses aim to strike a balance between private returns on investment into research and development, and the public right to access products. In 1995, the WTO TRIPS Agreement introduced the first global legal obligation to provide for IP protections in all economic sectors, making trade agreements one key legal arena for controversies over IP worldwide.

With TRIPS, the balance between investor and public interests began tipping in favour of private investors and FTAs that expand key provisions in TRIPS (such as extended patent terms, test data exclusivity, trade secrets, trademarks and more) further exacerbate this trend.[39] IP protections afford the IP holder a monopoly to produce products and bring them to market. These monopolies can impact not only on product price, but also structure global production networks for heavily protected products, and affect regulatory frameworks for marketing and sales (e.g. via the role of trademarks in advertising).

In medicines and medical products, transnational corporations hold much of the world's IP rights, while much of the world's population as well as humanitarian agencies and international aid organisations struggle to acquire affordable medicines.[40] Some exceptions anchored in IP clauses in trade agreements allow circumventing IP rights during a health emergency, and these have been reaffirmed at the WTO in the Doha Declaration on TRIPS and Public Health.[41] The Covid-19 pandemic has shown that countries rarely avail themselves of these tools.[42] In this context, a coalition of countries led by India and South Africa has launched multilateral WTO negotiations for a TRIPS waiver for all products required to fight the pandemic, for the duration of the pandemic (see box 3).[43] Many poor countries lack the institutional and bureaucratic capacity to take legally complex exceptions, while many wealthy countries lack the political will. Many poor countries also do not have the domestic productive capacity to produce medical products, nor the social transfer systems required to apply IP rules in trade agreements to their favour.

38 Ibid.

39 Coriat, B. et al (2006) "TRIPS and the International Public Health Challenges: Issues and Controversies", *Industrial and Corporate Change*, 15(6), 1033-1062.

40 Médecins Sans Frontières (2020) Access to Affordable Medicines Is a Growing Global Challenge: Europe Is No Exception, 15 February 2020.

41 WTO (2021) Declaration on the TRIPS Agreement and Public Health.

42 Médecins Sans Frontières (2021) Médecins Sans Frontières (MFN) Analysis of Communication from the European Union to the Council for TRIPS, 7 June 2021.

43 WTO (2021) TRIPS Council to Continue to Discuss Temporary IP Waiver, Revised Proposal Expected in May.

The resulting unequal access to medicines increasingly also affects populations in wealthy countries. Doctors without Borders, for example, reports that several European governments ration specific medicines, or have made them unavailable, due to unaffordable prices.[44]

Box 3: TRIPS Covid Waiver

In October 2020, India and South Africa proposed a WTO waiver to suspend patents and other TRIPS provisions in relation to the prevention, containment and treatment of Covid-19 until the majority of the world's population has developed immunity. Supported by over 100 WTO members, the proposal carves out policy space for governments to develop and scale up manufacturing capacities of medicines, vaccines, diagnostics and other medical products essential to fight Covid-19. The US, the EU, the UK, Switzerland and Norway, among others, initially dismissed the proposal because they believe that existing IPRs enable the effective development and supply of medical products. In a significant political shift, the TRIPS waiver found support from the United States in May 2021, and a text-based compromise for a Covid-19 vaccine waiver emerged among the EU, the US, India and South Africa in March 2022. The Ministerial Decision on the TRIPS Agreement taken at the WTO's 12th Ministerial Conference in June 2022 clarifies already existing flexibilities in TRIPS and temporarily (for 5 years) cuts red tape on the use of compulsory licenses for the export of Covid-19 vaccines to a limited number of importing countries that lack domestic manufacturing capacity. For many NGO activists, this falls far short of constituting a TRIPS waiver that can redress Covid-19 vaccine equity. This is a narrower outcome than initially intended, and, according to the NGO Médecins Sans Frontières/Doctors without Borders, demonstrates "a failed response on behalf of the WTO and global solidarity, and […] a negative precedent for future global health challenges".[45]

Under the current model of investor IP protection that is driven via trade agreements, drugs that are not deemed economically profitable suffer from lack of investment in research and development, and this includes drugs for conditions that disproportionately affect women.[46] Accessibility and affordability of medical products are not only relevant for the day-to-day workings of health systems, but also affect the conditions of social reproductive and care labour in home-settings. Anecdotal evidence suggests that gendered and other social norms and power relations play a role in determining what household members receive vital medicines in situations of scarcity.[47]

In food & nutrition, investor IP protections in trade agreements support corporate monopolies on genetic engineering and biotechnology. Patents on plant genetic resources have been linked to the establishment of certain agro-industry corporations as universal food producers, and have been linked to food security concerns in the developing world.[48] Along with trademarks, which play a role in the advertising and marketization of food products, IP protections shift food environments towards highly processed foods and food ingredients manufactured and

44 Médecins Sans Frontières (2019) Medicines Shouldn't Be a Luxury: It's Time to Stop Pharma's Big Profiteering, 8 May 2019.

45 Médecins Sans Frontières (2022) MSF Urges Governments to Reject the Draft COVID-19 Text Tabled at WTO Today, That Would Set a Negative Precedent, 4 April 2022.

46 Grom, T. (2018) Women's Healthcare: Drug Development, *PharmaVoice*, 1 January 2018.

47 Stiftung für Entwicklung und Frieden (2017) "Women Are Losing Out": Interview with Ranja Sengupta on the Effects of Trade and Investment Liberalisation, SEF: Insight 5/2017, Bonn: SEF.

48 Biggs, S. (1998) "The Biodiversity Convention and Global Sustainable Development" in Kiely, R. and P. Marfleet (eds.) Globalisation and the Third World, London: Routledge, pp. 121-146.

distributed by global food industries, and away from small-scale and subsistence farming, with a potential health toll on those gendered and marginalised populations that cannot afford healthy food choices.

The UK's FTAs with Japan, Australia and New Zealand replicate these issues or work to further tilt the balance in favour of corporate actors and investors by including IP provisions that go beyond what has been agreed in the WTO TRIPS Agreement. They reconfirm the WTO approach to IP including the Doha Declaration and Article 31bis TRIPS, which enable governments to take additional measures on patents in situations of emergency (Art 14.39 UK-Japan FTA, Art 15.6 UK-Australia FTA, Art 17.56 and 17.6 UK-New Zealand FTA). UK-Australia and UK-New Zealand explicitly exclude diagnostic, therapeutic or surgical methods for animal or human health, as well as plants and animals other than micro-organisms and essentially biological processes for the production of plants or animals other than non-biological and microbiological processes from patentability (Art 15.37 UK-Australia FTA, Art 17.53 UK-New Zealand). They enshrine test data exclusivity for agricultural chemical products for 10 years and for pharmaceutical and medical products for 5 years (Art 15 Section F UK-Australia FTA, Art 17.61 UK-New Zealand FTA) and 6 years (Art 14.42 UK-Japan FTA) from the date of marketing approval of previously approved products. Test data exclusivity expands the monopoly position of patent holders because competitors producing generic products are not allowed to rely on the patent holder's test data for regulatory and marketing approval of generic products.

In addition, UK-Japan includes a third-party Most Favoured Nation (MFN) clause, which stipulates that any more extensive IP protections negotiated in a future agreement with another country will automatically apply to UK-Japan trade (Art 14.5 UK-Japan FTA). Other novel clauses that cannot be found in TRIPS include a provision to promote public awareness around IP (Art 14.7 UK-Japan FTA), which effectively commits governments to weigh in on the public debate around IP protection on the side of corporate and investor interests. The provision is more cautiously formulated in UK-Australia and UK-New Zealand, which ask parties to "use reasonable efforts" (Art 15.94 UK-Australia FTA) and to "endeavour to promote public awareness of the importance of respecting intellectual property rights, including in the digital environment, and the detrimental effect of the infringement of intellectual property rights" (Art 17.87 UK-New Zealand). UK-Japan also includes enforcement provisions in the digital environment (Art 14.59 UK-Japan FTA, Art 15 Sub-Section J.5 UK-Australia FTA, Art 17 Sub-Section K.5 UK-New Zealand FTA), which has previously constituted a legal grey area for trade-related IP protection.

The Agreements in Principle signed in preparation for the Australia and New Zealand FTAs stated that the agreements will not affect the cost of medicines (Art 3.3 UK-Australia AiP and Art 16 UK-New Zealand AiP). Through what mechanisms this will be achieved was not outlined in the Agreements in Principle and is not clear from the IP chapters in the FTAs. It would be interesting to gain clarity on what negotiators of the Agreements in Principle had intended when agreeing these matters, as guaranteeing return on investment is the dominant rationale for providing IP protections via trade agreements.

3.4 Services

Service trade liberalisation aims to provide for the free flow of services, which constitute the bulk part of the productive economy in advanced countries (in the UK, 80% of GDP is made up of services).[49] Service trade liberalisation is based on the assumptions that transnational competition will boost cost-effectiveness, innovation and quality of service delivery and that domestic service providers will benefit from the opportunity to access markets abroad. Private service delivery differs from public service delivery because the former is based on the profit motive, while the latter is based on the principle of universal and equitable provision. Once a service sector has been liberalised in a trade agreement, this does not preclude the service from being delivered as a public service, but it will introduce competition from private service providers, that are entitled to market access under the trade agreement.

Individual service sectors are either liberalised entirely in a trade agreement, or certain aspects of the operation of the service are opened to transnational competition. Trade agreements usually differentiate remote service delivery, establishment of foreign providers, and movement of persons (health and care professionals and patients). Trade agreements also differ in the degree of opening provided and in how or if certain sectors are entirely excluded.[50]

In terms of health systems, different categories of services are implied in their day-to-day operation, ranging from health services and social services to financial services, professional services, research, IT and more. Key to understanding the UK debate around privatisation of the NHS via trade agreements is the fact that liberalisation commitments in all service sectors that are part and parcel of the day-to-day running of the NHS will impact on how the NHS will go about its work in the future. The same is true for the social care sector.

Women are not only among the prime users of public services. When health systems do not provide universal care, care work is pushed into domestic settings, where social norms continue to ascribe it to women, as witnessed during the Covid-19 pandemic.[51] Women are also disproportionately employed in the health system. In England, for example, 53% of the working population are men and 47% are women, while 23% of the NHS workforce are men and 77% are women.[52] How migration of health care staff under movement of labour service liberalisation commitments affects conditions in the labour market is thus of key interest for women and other minorities working in the NHS.

In terms of food & nutrition, food processing services as well as advertising, communication, and retail services are all of interest. Trade liberalisation in these areas can affect food environments by strengthening the presence and market position of transnational service providers, including not only agri-industry but also transnational supermarket and fast-food chains, that bring to market highly processed foods. It can also limit policy space to regulate

49 Office for National Statistics (2019) Services Sector, UK: 2008-2018.

50 Koivusalo, M. (2014) "Policy Space for Health and Trade and Investment Agreements", *Health Promotion International*, 29(1), 29-47.

51 UN Women and Women Count (2020) Whose Time to Care: Unpaid Care and Domestic Work during COVID-19, 25 November 2020, New York: UN Women.

52 NHS Employers (2021) Gender and the NHS.

unhealthy foods, alcohol and tobacco industries.[53] As under other areas of food trade liberalisation, the poorest households disproportionately carry the associated health costs.

Box 4: Service liberalisation – negative list vs positive list approach

Service liberalisation was first included in trade agreements under the General Agreement on Trade and Services (GATS) of the World Trade Organization (WTO) adopted in 1994. The GATS takes on a so-called "positive list" approach, whereby governments list the service sectors of the economy that they would like to liberalise, as well as the level of liberalisation commitments they would like to take. Most FTAs follow a so-called "negative list" approach, whereby governments list the service sectors of the economy that they do not want to liberalise. All non-listed service sectors are automatically fully liberalised. A negative list approach provides much higher levels of service trade liberalisation. Critics argue that it produces a chilling effect on government's ability to correct market failure in service sectors and that technological and other changes can generate new service sectors that were not conceivable at the time of the negotiation of a trade agreement, that then may escape government regulation, such as e.g. the digital economy.

The UK-Japan FTA takes a far-reaching approach to service trade liberalisation (Chapter 8 UK-Japan FTA, Chapters 8, 9 and 10 UK-Australia FTA and UK-New Zealand FTA). All three negotiations take a so-called negative list approach (see box 4), which makes liberalisation automatic, except for those service sectors and/or modes of delivery that are explicitly excluded. They also explicitly include central, regional and local levels of government and non-governmental bodies in the exercise of authorities delegated by them (Art 8.2 UK-Japan FTA, Art 8.1 UK-Australia FTA, Art 9.1 UK-New Zealand FTA). All three agreements exclude air services, audio-visual services, and procurement. UK-Australia and UK-New Zealand also exclude services supplied in the exercise of government authority (that is to say on a non-commercial basis and with no economic competition). They have separate chapters for financial services, on the basis of which no restrictions for health services are made (Chapter 8 UK-Japan FTA, Chapter 8 UK-Australia FTA, Chapter 9 UK-New Zealand FTA). In the Japan agreement, the UK made explicit exclusions and exceptions for professional services, research and development services, business services, communication services, transport services, energy and agriculture (Annex 8-B UK-Japan FTA). In the Australia agreement, the UK excluded legal services, intellectual property agents, veterinary services, business services, communication services, transport services and energy-related activities (Annex I UK-Australia FTA). The New Zealand agreement goes furthest in exclusions from liberalisation, as the UK makes limitations to liberalisation in health-related professional services and retail of pharmaceuticals, and health and social services in its schedule, in addition to the other sectors also excluded in the Japan and Australia deal (Annex II UK-New Zealand FTA). Exceptions by and large assure that qualification requirements of professionals and domestic regulations in the relevant sectors can be maintained.

53 Barlow, P. (2020) "COVID-19, Trade and Health: This Changes Everything? Comment on "What Generates Attention to Health in Trade-Policy Making? Lessons from Success in Tobacco Control and Access to Medicines: A Qualitative Study of Australia and the (Comprehensive and Progressive) Trans-Pacific Partnership"", *International Journal of Health Policy Management*, DOI:10.34172/ijhpm.2020.220.

The various service sectors relevant to the operation of health systems and to food environments are therefore in principle liberalised under the three texts, although to a lesser degree in UK-New Zealand. There are also so-called "ratchet" clauses in all three FTAs, which imply that future unilateral liberalisations by one party are automatically covered under the agreement (Art 8.12 1 (c) UK-Japan FTA, Art 8.7 1(c) UK-Australia FTA, Art 9.8 1(c) UK-New Zealand FTA).

Trade agreements typically provide regulatory space for governments by means of general exceptions. Art 8.3 UK-Japan, Chapter 31 UK-Australia and Chapter 32 UK-New Zealand set out the general exceptions to service and investment liberalisation commitments. UK-Australia and UK-New Zealand incorporate the relevant WTO provision (GATS Art XIV) *mutatis mutandis*, while the UK-Japan provision follows the structure and wording of general exception clauses in the WTO (notably GATT Art XX and GATS Art XIV). It requires governments to ensure that any policy measures taken in the interest of a non-trade public policy goal do not constitute "an arbitrary and unjustifiable discrimination" or "a disguised restriction on international trade", in a section of the provision that is called the "chapeau". Unlike the WTO provisions, which contain a longer list of permissible areas of public policy, UK-Japan only allows trade restrictive measures that serve to protect public security, public moral, public order, and health, as well as certain laws required for anti-fraud, privacy and taxation (Art 8.3 UK-Japan FTA). As far as health is concerned, UK-Japan follows the WTO standard by requiring the exceptional measure to be "necessary" to protect health, unlike other policy areas such as preservation of natural resources, where the government only needs to prove that their measure is "relating to" the policy goal in question under WTO rules. These legal standards for general and health exceptions in trade agreements have made it difficult in practice for governments to defend exceptional measures in trade dispute resolution. Such international legal difficulties shape public policy choices at the point of formulation and make liberalisation the default position of the government, even in the face of market failure and negative public policy and societal impact.

There are so-called "Third Party MFN" clauses in all three texts (Art 8.9 UK-Japan FTA, Art 8.4 UK-Australia FTA, Art 9.6 UK-New Zealand FTA). They stipulate that if one party grants any other country more extensive market access or market access conditions in trade agreements to be negotiated in the future, these benefits will automatically apply to the parties to the agreement. Given that there are strong vested interests in the US and Canada that have long lobbied for the opening up of the European healthcare sector, it is not inconceivable that the UK government will make more wide-reaching liberalisation commitments concerning services essential to the workings of the health system in trade negotiations with these countries. It is also possible that free movement of labour will be enabled in future agreements, in particular in the context of staff shortages in the NHS following Brexit. Where such labour migrates from countries with low labour costs, this may result in downward pressures on wages in the NHS.

3.5 Government Procurement

Government Procurement rules in trade agreements apply to goods and services and are of relevance because the acquisition of goods and services from private economic operators is part and parcel of the running of a health system and of the general regulatory environment for food markets. Traditionally, WTO rules refer to national level public contracts only, but in recent years Government Procurement clauses in FTAs have tended to include sub-national levels of governance, such as regional or local authorities.[54] A number of possible features are of concern. They include an obligation to procure goods and services from the most cost-effective bidder, irrespective of other criteria relating to the quality of goods and services, or the manner in which they are produced or provided; loss of national or local know-how on the service or good acquired, and administrative issues resulting from unintelligible networks of overlapping contractual obligations.[55]

All three new FTAs confirm the WTO Government Procurement Agreement (GPA) and go beyond it in certain regards, as well as falling short of the WTO baseline in other regards.[56] In terms of their approach to public procurement, the agreements integrate the wording of Art XV GPA which allows procuring entities to award a contract based on either the most advantageous tender, or on the lowest price (Art 10.11 UK-Japan FTA, Art 16.14 UK-Australia FTA, Art 16.16 UK-New Zealand FTA). UK-Australia and UK-New Zealand go further and contain general exceptions clauses that allow adopting measures to protect public morals and security; human, animal and plant life and health (including environmental measures); intellectual property; and measures relating to goods and services of persons with disabilities, philanthropic institutions and prison labour (Art 16.3 UK-Australia FTA, Art 16.3 UK-New Zealand FTA). They also contain specific provisions that allow procuring entities to take into account environmental, social and labour considerations (Art 16.17 UK-Australia FTA, Art 16.10 UK-New Zealand FTA). Although an inclusion of public health outcomes, and an assurance that social outcomes include gendered and other forms of social inequality, would be welcome in the UK-Australia and UK-New Zealand texts, the existing wording is preferable to the WTO GPA and the UK-Japan FTA from the perspective of health and social reproduction. In principle, it sets a welcome precedent for negotiations with the US, Canada and others.

3.6 Investment

While there has traditionally been resistance to incorporating international investment rules in trade agreements, most notably when the Multilateral Agreement on Investment failed at the WTO in 1998, over recent decades investment rules have found their way into bilateral and regional trade agreements. Proponents argue that investment rules provide stability for investors and can help attract Foreign Direct Investment. However, studies struggle to establish a clear link between the two.[57] Opponents argue that investment rules can have a chilling effect

54 Koivusalo, M. (2014) "Policy Space for Health and Trade and Investment Agreements", *Health Promotion International*, 29(1), 29-47.

55 Ibid.

56 Sanchez-Graells, A. (2022) The Public Procurement Chapter in the UK-Australia Free Trade Agreement – GPA+ or GPA Complex?

57 Brada, J. et al (2020) "Does Investment Protection Increase Foreign Direct Investment? A Meta-Analysis", *Journal of Economic Surveys*, doi.org/10.1111/joes.12392.

on government regulation in wider areas of public policy.[58] Investment protection provisions in particular are criticised for putting a costly tag on adjusting economic policies for public policy reasons if investors decide to take governments to investor-state arbitration for compensation of losses.[59] This investor right is typically anchored in contentious Investor-State Dispute Settlement (ISDS) clauses.

Box 5: Investor-State Dispute Settlement (ISDS)

Investor-State Dispute Settlement is a mechanism included in many trade and investment agreements. Its purpose is to mitigate risks associated with investment abroad, by allowing investors to take legal action against foreign governments for expropriation or discriminatory practices, including indirect damage caused by regulatory change. It is a contentious provision that has been widely critiqued for undermining the power of national governments to act in the interest of over-arching public policy goals such as environmental, labour, social and/or human rights protections. Concerned that transnational investors would use ISDS provisions to gain compensation for losses due to lockdown and other Covid-related measures, the Colombia Centre on Sustainable Investment called for a global ISDS moratorium during the Covid crisis.[60] The United Nations Conference on Trade and Development (UNCTAD) publishes an annual review of ISDS cases and keeps track of existing reform proposals and initiatives.[61]

In addition to liberalisation commitments in services and government procurement, investment rules can damage the equity and universal accessibility of health care systems,[62] in particular where the agreements do not adequately safeguard exclusions and the government's right to regulate health systems. Services liberalisation (for example on advertising) and investment commitments can limit policy space to regulate unhealthy foods, alcohol and tobacco industries.[63] Australia in particular has had negative experiences with this, when Philip Morris challenged its plain packaging tobacco rules under one of Australia's investment agreements. Overall, existing clauses work to curtail government intervention and spending in health and social policy.[64]

ISDS is currently explicitly excluded from all three agreements (Art 8.9.4 UK-Japan FTA, Art 13.6 UK-Australia, Art 14.7 UK-New Zealand). In addition, UK-Australia and UK-New Zealand stipulate that an investor must be "carrying out substantial business activities in the territory" of the Party whose nationality it claims, in order to access the benefits negotiated under the the FTA's investment chapter (Art 13.1(a) UK-Australia FTA, Art 14.2 UK-New Zealand FTA). In UK-New Zealand, footnote 3 to Art 14.2 clarifies that this means that the investor must

58 Harrison, J. and M.A. Stephenson (2018) 2018 WGB Briefing: Trade and Investment, London: Women's Budget Group.

59 Labonté, R. et al (2016) "The Trans-Pacific Partnership: Is It Everything We Feared for Health?", *International Journal of Health and Policy Management*, 5(8), 487-496.

60 Columbia Centre on Sustainable Investment (2020) Call for ISDS Moratorium During COVID-19 Crisis and Repsonse, 6 May 2020.

61 UNCATD (2020) International Investment Agreements Reform Accelerator.

62 Jarman, H. and S. Greer (2010) "Crossborder Trade in Health Services: Lessons from the European Laboratory", *Health Policy*, 94(2), 158-163.

63 Barlow, P. (2020) "COVID-19, Trade and Health: This Changes Everything? Comment on "What Generates Attention to Health in Trade-Policy Making? Lessons from Success in Tobacco Control and Access to Medicines: A Qualitative Study of Australia and the (Comprehensive and Progressive) Trans-Pacific Partnership"", *International Journal of Health Policy Management*, DOI:10.34172/ijhpm.2020.220.

64 McNamara, C. et al (2021) "Glossary on Free Trade Agreements and Health Part 2: New Trade Rules and New Urgencies in the Context of COVID-19", *Journal of Epidemiology & Community Health*, 75(4), 407-412.

demonstrate "a genuine link to the economy of that Party", which is aimed at preventing forum shopping by investors.

UK-Japan stipulates that the exclusion of ISDS will come under review should one of the parties sign a trade agreement containing an ISDS clause in the future (Art 8.5.3 UK-Japan FTA). It is not clear that UK negotiators will be excluding ISDS in their attempts to join CP-TPP or in negotiations with Canada, the US, Mexico or India. Should ISDS be included in any of these agreements, Australian and New Zealand-based investors could make claims against the UK in cases where they operate in countries with which the UK has a trade and/or investment agreement that includes ISDS.

4. Policy recommendations for UK trade agreements on health systems and food & nutrition:

- Apply gender-based and health-based impact assessments and monitoring and remedy negative impacts of trade agreements on gendered, health, and other social inequalities.
- Include a wide range of civil society actors in trade policy decision-making, including those representing public health, food safety and food security, and gender equality concerns.
- Take implications for UK food environments and dietary habits into account when negotiating agricultural liberalisation commitments.
- Reaffirm subsidy and safeguard provisions under the WTO Agreement on Agriculture.
- Under regulatory standards explicitly allow going beyond international standards, remove least trade restrictive requirement for measures meeting the public policy goal, enshrine the precautionary principle, and close special access routes for vested interests or include all societal stakeholder groups.
- Remove provisions in intellectual property chapters that go beyond WTO obligations.
- Exclude the NHS explicitly and fully from trade agreements.
- Adopt positive-list approach to service liberalisation and exclude service sectors relevant for the day-to-day running of the health system, expanding on or at a minimum following the UK exclusions in the New Zealand deal.
- Take employment conditions in health system and domestic care settings into account when negotiating service liberalisation commitments.
- Remove least trade restrictive condition for public health exceptions and allow measures to be taken where they are "relating" to, not "necessary" for public health.
- Do not include clauses binding future policies (including so-called "third-party MFN" and "ratchet" clauses) unless there are effective public health carve-outs.
- Adopt UK-Australia and UK-New Zealand approach to Government Procurement, adding "public health outcomes" to the list, making clear that "social outcomes" may include gendered and other social inequalities, and removing the non-discrimination requirement for these carve-outs.

- Adopt the UK-New Zealand model on investor-state dispute settlement, carving it out entirely and setting "genuine economic link" requirements for accessing benefits, or at a minimum explicitly exclude investor-state dispute settlement in the domain of public health and gender equality.

5. Useful resources

Friel, Sharon, et al. "Monitoring the impacts of trade agreements on food environments." *Obesity Reviews* 14 (2013): 120-134.

Koivusalo, Meri. "Policy space for health and trade and investment agreements." *Health Promotion International* 29.suppl_1 (2014): i29-i47.

McNamara, Courtney, Ronald Labonté, Ashley Schram, Belinda Townsend. "Glossary on free trade agreements and health part 2: New trade rules and new urgencies in the context of COVID-19", *Journal of Epidemiology & Community Health*, 75 (2021): 407.

Sanchez-Graells, Albert, *The Procurement Chapter in the UK-Australia Free Trade Agreement – GPA+ or GPA Complex?* (2022), available at http://dx.doi.org/10.2139/ssrn.4014409.

Smith, Richard D., Kelley Lee, and Nick Drager. "Trade and health: an agenda for action." *The Lancet* 373.9665 (2009): 768-773.

Trade and Public Policy Network. *What is in the UK-Australia FTA? Preliminary Reflections* (2022), available at https://www.lse.ac.uk/law/Assets/Documents/news/tapp.pdf.

Trommer, Silke. "Trade, health and social reproduction in a COVID world." *Globalizations* (2021): 1-11.

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