

Accepted Manuscript

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PII: S0277-9536(16)30685-2

DOI: [10.1016/j.socscimed.2016.12.017](https://doi.org/10.1016/j.socscimed.2016.12.017)

Reference: SSM 10958

To appear in: *Social Science & Medicine*

Received Date: 11 March 2016

Revised Date: 2 December 2016

Accepted Date: 11 December 2016

Please cite this article as: McNamara, C., Trade liberalization and social determinants of health: A state of the literature review, *Social Science & Medicine* (2017), doi: 10.1016/j.socscimed.2016.12.017.

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Trade liberalization and social determinants of health: a state of the literature review

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2 **Abstract**

3 The health impacts of trade liberalization are often described in relation to access to medicines,
4 changing dietary patterns, tobacco use and alcohol consumption. The impacts of trade liberalization
5 on the social determinants of health (SDH), are by contrast, less well known. Missing is an account
6 of how liberalizing processes identified across different research areas relate to each other and
7 how the association between trade liberalization and health is conceptualized within each of them,
8 especially with reference to SDH. This paper presents a systematic review which provides a more
9 complete picture of the pathways between trade liberalization and health, with special attention to
10 SDH pathways. This picture captures the interrelationships between different areas of investigation,
11 along with current limitations of our understanding and recommendations for future research.

12 **1. Introduction**

13 Fifteen years ago it was claimed that 'globalisation is good for your health, mostly'¹. This claim,
14 based on the idea that globalization ultimately leads to greater wealth and thus better health, has
15 since been forcefully challenged. Early challengers to this claim offered frameworks which
16 synthesized the complex pathways between globalization and health and identified a range of global
17 processes with potential negative health implications²⁻⁴.

18 Since these early efforts, the landscape of trade negotiations has changed. The latest round
19 of negotiations among members of the World Trade Organization (WTO) has seen little progress
20 since 2008. At the same time, there has been a proliferation of bilateral and regional trade
21 agreements (RTAs) which are generally negotiated in secret and characterized by 'deeper'
22 commitments than those of the WTO.⁵ These bilateral and regional trade agreements not only
23 concern typical trade issues, such as trade in goods and services, but also have implications for
24 domestic policies in the areas of intellectual property, government procurement, environmental
25 regulations, labour standards and public health policy making more generally.⁶ A major concern with
26 new generation RTAs is their inclusion of investor-state dispute settlement chapters, which give
27 foreign investors the right to sue governments for regulatory changes that may affect the value of
28 their investment.⁷

29 Research has also since moved towards more nuanced understandings of the globalization
30 and health relationship. One process of globalization that has received greater attention is trade
31 liberalization. In public health literature, processes of trade liberalization are often related to access
32 to healthcare services, medicines, nutritional health and consumption of tobacco and alcohol. The

35 impacts of trade liberalization on the social determinants of health (SDH), i.e. the social conditions

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36 that shape people's ability to lead healthy lives, by contrast, are less well known^{8,9}.

37 Missing from the literature is an account of how liberalizing processes identified across these
38 different research areas relate to each other and how the association between trade liberalization
39 and health is conceptualized within each of them, especially within the context of SDH. The aim of
40 this paper is to provide such an account, with a focus on current limitations to our understanding and
41 recommendations for future research.

42 **2. Methods**

43 A systematic search for literature published up until the end of 2015 was conducted using the
44 Applied Social Science Index and Abstracts (ASSIA) database, PAIS International database, Econlit,
45 and the ISI Web of Knowledge. Literature was also searched using Google Scholar. Full details of the
46 search strategy are provided in Appendix A, though a brief sketch is provided here.

47 For literature to be included, articles must have explicated a clear analytical framework for
48 conceptualizing pathways between trade liberalization and health. Once articles were identified for
49 inclusion, a process of 'data extraction' was undertaken. Data was extracted from literature to
50 answer three research questions.

- 51 1. How is trade liberalization understood in analytical frameworks relating liberalization to health?
52 2. How is health conceptualized in these frameworks?
53 3. How do researchers explain the pathways mediating the liberalization and health relationship?

54 This method of reviewing the literature draws on configurative systematic review
55 methodology, which is interested in understanding the development of a research area¹⁰. Like other
56 configurational reviews, extracted data is synthesized narratively and the included literature was
57 critically appraised on its ability to answer the review's research questions¹⁰.

58 **3. Results**

59 Forty-three studies were identified for inclusion (Figure 1). Detailed information on the
60 extracted data is available in Appendix B.

61 **3.1 How is trade liberalization understood in analytical frameworks relating trade to health?**

63 globalization. Others discuss liberalization more exclusively in reference to the related contexts of
64 structural adjustment policies^{11,12}, aggregate shocks¹³, development^{14,15}, foreign policy¹⁶, GATS¹⁷,
65 and trade policy in general^{8,18–20}.

66 Among authors who use globalization to contextualize trade liberalization, many restrict
67 their analysis to economic globalization^{2,21–27}. Others consider globalization in relation to different
68 economic, political, technological, cultural, social and/or environmental domains^{3,4,28–32}.
69 Neoliberalism^{14,23–25,33–39} and the ‘Washington Consensus’^{33–35,37,40–42}, are often identified as
70 dominant forces shaping globalization. Many authors also emphasize the role of power relations (i.e.
71 the distribution of power among economic actors and political institutions) in shaping globalization
72 processes^{23,24,33–36,38,39,41–44}.

73 Trade liberalization is also often conceptualized by appealing to broad ideas of openness
74^{2,8,21,24,26,29,39,41,45,46}, market integration^{3,4,17,25,30,46,47} and trade flows^{4,14,25,30,32}. Trade liberalization is
75 also discussed with reference to a wide range of institutions, agreements, and policies.

76 Many authors include financial flows and foreign investment within conceptualizations of
77 trade liberalization^{2,3,18,25,26,28,36}, while others position these concepts in separate, albeit related,
78 domains^{12,33,38,39}. Trade liberalization itself is seldom explicitly defined in frameworks. Exceptions
79 are detailed in Table 1^{18–20,31,38,48}.

80 **3.2 How is health conceptualized?**

81 Frameworks are almost equally split between exploring overall health status outcomes
82 (n=21) and exploring health differences (n=22). Of those exploring overall health, chosen outcomes
83 vary in specificity. Some frameworks discuss health in very specific ways for example, in terms of
84 vulnerability to HIV/AIDS^{12,37}, whereas others explore more general areas of health such as nutrition-
85 related diseases^{19,20,47}, reproductive health¹⁸, mental health⁴⁰, occupational health⁴⁹ and chronic
86 diseases³⁸. The majority of frameworks conceptualize health broadly, with little mention of specific
87 outcomes.

88 Of frameworks exploring health differences, the majority frame these as 'health
89 inequalities'^{13,14,16,21,26–28,33–36,41,50}, while others employ the concept of 'health inequities'

90 ^{3,23,31,41,42}. While health inequalities typically refer to crude differences in health, health inequities

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91 are generally understood as avoidable and unjust differences in health⁵¹. Within these frameworks,
92 health differences are often conceptualized in broad terms, though some explore more specific areas
93 such as nutrition-related inequalities^{13,26,50}, inequalities in workers' health³⁶ and inequalities in non-
94 communicable diseases²¹.

95 **3.3 How do researchers explain the pathways mediating the liberalization and health relationship?**

96 A few studies included in this review explore the impact of liberalization on health, exclusive
97 of other processes of globalization^{8,18-20}. Three early frameworks play a significant role in setting the
98 foundation of later work, those by Woodward and colleagues², Labonté and Torgerson³ and Huynen
99 and colleagues⁴. A framework by Labonté and colleagues²⁴ also acts as the basis for a number of
100 frameworks.

101 In Woodward and colleagues² (Figures 2-3), liberalization can be seen as a part of a positive
102 feedback loop through which: “[i]ncreasing cross-border flows stimulate the development of global
103 rules and institutions, which promote the opening of economies, which increase the scale and scope
104 of cross-border flows” (p. 876).

105 In Labonté and Torgerson³ (Figure 3), trade liberalization is broadly contextualized in
106 reference to super-ordinate, global, domestic, community and household contexts. Aspects of
107 liberalization are identified at the global level, within the pathways of ‘macroeconomic policies’ and
108 ‘trade agreements and flows’. Within this first area, attention is drawn to loan conditionalities, which
109 are seen to negatively impact a range of health outcomes. In the second pathway, trade liberalization
110 is seen to have impacts across five domains: the physical environment, the social environment,
111 competitive pressures, regulatory space and capital markets. Within these domains, specific
112 liberalizing policies are not always explicated but generally speaking, pathways are drawn to
113 environmental degradation, the erosion of states’ ability to tax domestic wealth, a loss of domestic
114 policy space, and a crowding out of domestic investment.

115 In Huynen and colleagues⁴ (Figures 4-5), trade liberalization can be seen as an important
116 aspect of global markets, which in turn are seen to impact countries’ economic development and
117 trade. Economic development and trade are related to more proximal determinants of health,

118 including health services, lifestyle factors, and the physical environment. While the specific
119 relationships between liberalization and these determinants are not explicated, increased trade
120 flows are often identified as the main culprits.

121 Both a simple and a complex framework is presented by Labonté and colleagues²⁴ (figures 6-
122 7). These frameworks draw on work by Diderichsen, Evans and Whitehead⁵², which identifies the
123 following four main mechanisms in generating health inequities: social stratification, differential
124 exposure, differential susceptibility, and differential consequences. Based on pathways empirically
125 modelled by Cornia and colleagues⁵³, six factors are noted by Labonté and colleagues²⁴ for mediating
126 the relationship between globalization and health: "material deprivation, medical progress, acute
127 psychosocial stress, unhealthy lifestyles, stratification and lack of social cohesion, and positive and
128 negative shocks" (p. 26). These factors are seen to interact across four main pathways to affect
129 health: asymmetries in power and resources, trade liberalization, aid and investment, and basic
130 needs. Trade liberalization is related to a limited number of issues namely economic insecurity,
131 declines in public revenues, trade in health services, and food insecurity.

132 Drawing on Labonté and colleagues'²⁴ framework, later frameworks incorporate more SDH-
133 focused pathways. This includes the framework by Blouin and colleagues⁸. Leaving aside the more
134 widely studied impacts of trade in relation to access to medicines and health services, the authors
135 identify four pathways through which liberalization can impact health: material deprivation, acute
136 psychosocial stress, unhealthy lifestyles, and high level of stratification and lack of social cohesion.
137 Four key factors are respectively associated with these pathways: income, income inequality,
138 economic insecurity and unhealthy diets. Specific liberalization policies however, are not always
139 identified. In relation to income, the debate between trade liberalization, growth and poverty is
140 recounted. The claim that trade enhances growth, reduces poverty, and thus improves health is
141 exchanged for a more nuanced assessment. The authors argue that "trade liberalization alone is
142 insufficient to boost the economy" and that "[c]omplementary policies are needed to ensure that
143 trade openness leads to a high level of growth" (p. 503). Labour markets and wage differentials are
144 of primary concern in reference to income inequality and the movement of workers between sectors

145 in reference to economic insecurity. In terms of unhealthy lifestyles, liberalization is related to diet
 146 and nutrition via changes in food prices, increased availability of unhealthy foods, growing
 147 urbanization and changes in lifestyles.

148 Outside of these early and influential frameworks, other frameworks included in this review
 149 offer many interpretations of the manifestations of trade liberalization. This review identified four,
 150 non-mutually exclusive contexts through which liberalization is understood to impact health:
 151 increased flows of goods and people; agricultural and food trade; structural adjustment policies; and
 152 labour markets.

153 **3.3.1 Increased flows of goods and people**

154 Within the first context, trade liberalization is seen as playing a central role in increasing
 155 communicable and non-communicable diseases. Lee links trade liberalization to communicable
 156 diseases through a range of intermediary determinants of health³². Without specifying specific
 157 liberalizing mechanisms, communicable diseases are seen to increase with the “greater worldwide
 158 mobility of people, through business, tourism, rural-urban migration and displacement” (p. 256).
 159 Other intermediary determinants identified include increased flows of animals and plants.
 160 Woodward and colleagues²⁷ also underscore this latter association, again however, specific
 161 liberalizing strategies are not named.

162 In terms of non-communicable diseases, Bettcher and colleagues⁵⁴ note that “the health risks
 163 and benefits associated with the liberalization of trade in goods are highly dependent on the nature
 164 of the commodities concerned” (p. 5). The authors focus their discussion on the health impacts of
 165 increased tobacco trade which is seen to be facilitated by “significant reductions in tariff and non-
 166 tariff barriers to trade” (p. 5). Woodward and colleagues²⁷ supplement this conception by
 167 acknowledging transnational tobacco corporations “as among the strongest proponents of tariff
 168 reduction and open markets” (p. 7). Doyal highlights the impacts of tobacco trade on women, but
 169 while citing ‘liberalization’ as the culprit behind gendered consumption trends, does not name
 170 specific liberalizing policies²⁹.

171 A more comprehensive consideration of how liberalization impacts non-communicable
 172 diseases is provided by Labonté and colleagues³⁸ and Mohindra and colleagues³⁹. Trade liberalization

173 is defined by Labonté and colleagues³⁸ in terms of “eliminating quotas, reducing tariffs, and
 174 privatizing state agencies” (p4). Both articles outline pathways from liberalization to increased
 175 tobacco and alcohol consumption, mainly in low- and middle-income countries (LMICs). In terms of
 176 tobacco, the main liberalization strategy discussed is the lowering of import tariffs however,
 177 liberalization is also related more generally to the growth of tobacco production in LMICs. Shifts to
 178 tobacco crop production are noted to increase food insecurity for some farmers, and are also linked
 179 to direct health risks associated with the harvesting of tobacco. In terms of alcohol, the authors
 180 relate reduced import tariffs to a greater diversity of alcohol products. The liberalization of
 181 advertising services is seen to be related to greater and more dangerous consumption of alcohol
 182 among youths and vulnerable groups. The authors also relate greater alcohol consumption patterns
 183 globally to reductions in state monopolies.

184 Beyond communicable and non-communicable diseases, Singer¹⁴ broadly relates
 185 liberalization to an increased flow of illegal drugs, noting a range of health impacts, as well as
 186 differential influences across “countries of production, countries of trans-shipment, and countries of
 187 targeted consumption” (p. 469).

188 **3.3.2 Agricultural and food trade**

189 In the context of agricultural and food trade, an oft cited concern is that industrialized
 190 countries continue to protect their agricultural producers while developing countries face increasing
 191 pressure to further liberalize imports. Generally speaking, this liberalization is seen to negatively
 192 affect the livelihoods of agricultural producers in developing countries who must compete with
 193 cheap imports^{24,38}. Beyond this consideration, framework authors discuss agricultural and food
 194 liberalization policies largely in relation to food security and nutrition.

195 **Food Security**

196 The relationship between trade liberalization and food security is discussed in reference to
 197 lower-income countries where liberalized food markets are related to greater food insecurity via
 198 instabilities in global food prices^{24,38}, reductions in food subsidies¹², and cash cropping schemes^{24,38}
 199 (cash crops refer to agricultural products produced for commercial purposes). Reductions in food
 200 subsidies are the only specific liberalizing strategy discussed in this area, although reduced food and

201 fuel import tariffs are noted for their role in tempering the negative impact of food price shocks¹³.

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202 Reductions in food subsidies are related to an increase in women and children's exposure to HIV/AIDs
203 in Sub-Saharan Africa¹². The authors of this study note that reductions in food subsidies increase the
204 price of food, which in turn can reduce access to basic commodities. This can increase women and
205 youth's exposure to commercial sex and sex abuse. Women's exposure to commercial sex and sex
206 abuse can also increase the exposure of infants to mother-to-child HIV transmission¹².

207 **Nutrition**

208 In terms of nutrition, framework authors focus on what is termed the 'nutrition transition' to
209 explain much of the relationship between liberalization and nutritional outcomes. The nutrition
210 transition represents a shift in consumption of traditional staples, such as cereals and complex
211 carbohydrates, to more energy dense foods and refined carbohydrates⁵⁵. In this context, various
212 import and export liberalizing strategies are noted for their differential impact across low-, middle-,
213 and high-income countries.

214 Thow²⁰ provides one of the most comprehensive understandings of trade liberalization's impact
215 on the nutrition transition. The author uses a range of trade agreements to outline three broad policy
216 areas through which liberalization may impact the nutritional transition in lower-income countries:
217 trade in goods; trade in investment and services; and support for domestic production.

218 Within the first area, both import facilitation and export promotion policies are identified as
219 primary determinants of health. In terms of import facilitation, trade agreements of the World Trade
220 Organization (WTO) are emphasized for their role in liberalizing trade in goods through the reduction
221 of both tariff and non-tariff barriers (e.g. "quantitative restrictions, import licensing, variable levies,
222 import quotas, and technical barriers" (p. 2153)). The General Agreement on Tariffs and Trade
223 (GATT) is identified as the key agreement within this pathway, since the schedule of commitments
224 attached to it indicates when countries will reduce their tariffs and by how much. The Agreement on
225 the Application of Sanitary and Phytosanitary Standards and Technical Barriers to Trade Agreement
226 are also identified for their role in committing countries to remove "restrictions and import
227 regulations that are disguised protectionist measures" (p. 2151). Finally, the Most Favoured Nation
228 principle is highlighted for dictating that "all nations should be given equal treatment, meaning that

229 countries cannot use trade barriers to discriminate based on the source of imports" (p. 2152).

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230 Potential positive health impacts are acknowledged for areas with problems of undernutrition, but
231 nutritional implications are otherwise identified as largely negative.

232 In terms of export promotion, cash crops are found to decrease production and consumption of
233 traditional domestic staples. Currency devaluation is also highlighted as an export promotion
234 liberalizing strategy. This strategy is highlighted for potentially increasing the costs of imported goods
235 but both negative and positive diet-related implications may follow. Negatively, increases in the cost
236 of food can result in reduced food consumption and dietary diversity. On the other hand, "if
237 domestic production has the capacity to respond, currency devaluation can have positive dietary
238 effects through increasing the availability and consumption of locally produced goods" (p. 2154).

239 Liberalization in the context of investment and services is seen to effect food systems for
240 example, by increasing food industry investment, creating more new foods and food service
241 establishments and increasing food marketing. These effects are seen to increase the availability of
242 processed foods, stimulate the local industry, improve food storage and safety, and increase the
243 availability and awareness of "high profit margin novel foods" (p. 2152). On balance, these
244 mechanisms are seen to increase people's consumption of processed, refined and pre-prepared
245 foods.

246 In Thow's final pathway, the removal of farmer subsidies and the removal of import tariffs on
247 locally produced goods are highlighted as key aspects of trade liberalization. A range of agreements
248 are associated with these processes which are seen to reduce the overall cost of processed foods and
249 increase the attractiveness of investment into the food industry.

250 Using the concepts of 'dietary convergence' and 'dietary adaptation', Hawkes⁵⁰ explores how
251 global market integration influences dietary patterns in middle-income countries. Dietary
252 convergence signifies "increased reliance on a narrow base of staple grains, increased consumption
253 of meat and meat products, dairy products, edible oil, salt and sugar, and a lower intake of dietary
254 fibre"⁵⁶ (p.9). Dietary adaptation is defined as "increased consumption of brand-name processed and

255 store-bought food, an increased number of meals eaten outside the home and consumer behaviours

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256 driven by the appeal of new foods available”⁵⁶.

257 Two concepts of liberalization are explored in this framework: increased ‘market-orientation’ and
258 the ‘opening of communications markets’. Increases in market-orientation are seen to have occurred
259 in middle-income countries within the context of structural adjustment, through regional and
260 bilateral trade agreements, as well as through GATT and the Agreement on Agriculture. Increased
261 market-orientation in general is seen to have increased trade flows, foreign investment and the size
262 of transnational food companies. These processes are in turn noted to “have altered the supply of
263 foods associated with the nutrition transition” (p. 3). The integration of vegetable oil into Brazilian,
264 Chinese and Indian markets is explored and used to exemplify the framework. In this case-study,
265 liberalization policies in Brazil, such as lowered import tariffs and export taxes, in combination with
266 investment liberalization and currency devaluation, are noted for their role in the convergence of
267 vegetable oil consumption in China and India. The opening of the communications market is
268 identified as driving the globalization of food marketing which is in turn highlighted for its role in
269 promoting energy-dense and highly-processed foods, encouraging both greater consumption and
270 production of these products.

271 Turning to high-income countries, Smith and Signal²⁶ discuss how the nutrition transition in
272 LMICs has increased global demand for dairy products. While it is acknowledged that this trend has
273 had positive impacts on New Zealand's dairy exporting farmers and producers, and thus positive
274 impacts on the national economy, these advantages are noted to have come at the expense of local
275 consumers, “especially those which are socioeconomically disadvantaged” (p. 2). Reform measures
276 associated with liberalization are the “removal of government subsidies, reduction of import tariff
277 and non-tariff barriers, removal of control on interest rates, wages and prices, restructuring and sale
278 of government assets and reform of tax structures including the application of a neutral good and
279 services tax” (p. 3). These reform measures are seen to have played a role in increasing the price of
280 milk in New Zealand and are directly related to greater nutritional health inequalities, with lower
281 income New Zealanders more likely to choose cheaper, nutritionally poor beverages.

282 **3.3.3 Structural adjustment policies**

283 In the third context, structural adjustment policies (SAPs) are discussed in reference to loan
284 conditionalities imposed by either the International Monetary Fund (IMF) or World Bank. In this
285 context, liberalization is universally seen as a fundamental aspect of SAPs, along with other
286 macroeconomic stability policies.

287 Overall, framework authors relate SAPs to: the deterioration of public goods for health,
288 weakened healthcare and educational systems, increased unemployment, poverty and income
289 inequality, deteriorating living conditions, impeded tobacco control efforts, increased infectious
290 diseases, deteriorating nutritional outcomes and worsening child and maternal mortality^{22,34,35,37,41,57}.

291 In terms of specific liberalizing policies, reductions in consumption subsidies are related to
292 worsened nutritional outcomes, reductions in household income and increased vulnerability to
293 HIV/AIDS for women and children in Sub-Saharan Africa.

294 In the context of SAPs, liberalization is also noted to have potentially positive health impacts
295 through import liberalization (in conjunction with export promotion policies) which “may reduce
296 imbalances in the import-export ratio resulting in economic growth and reduced poverty”¹².

297 **3.3.4 Labour markets**

298 Three frameworks provide a broad description of the relationship between labour markets,
299 trade liberalization and health^{24,36,43}. These frameworks contextualize both labour markets and
300 liberalization within wider socio-political contexts; however, specific liberalizing mechanisms are not
301 delineated.

302 Other frameworks provide more conceptually developed notions of pathways to health.
303 Corrigall and colleagues⁴⁰ for example, explore the relationship between global trade and mental
304 health. Here liberalization is seen as “a key principle of WTO agreements” which seeks to “ensure that
305 trade is not unnecessarily restricted by tariff or non-tariff barriers” (p. 336). Whereas tariff barriers
306 are understood as those which restrict trade through financial methods, such as import taxes, non-
307 tariff barriers are seen to be those which “refer to laws and regulations that affect trade” (p. 336).
308 Differential impacts are noted across industrialized countries and LMICs. In industrialized countries,
309 impacts are noted to be characterized by job losses. In LMICs, trade liberalization is seen to increase

310 the supply of unskilled labour, depress wages and deteriorate working conditions. These impacts in
311 turn, are seen to increase work-stress which is noted to associate with a range of health outcomes
312 including depression, unhealthy lifestyle habits, alcohol abuse and musculoskeletal disorders.

313 In Loewenson⁴⁹, “liberalization is associated with deregulation of production laws” (p. 866) and
314 health is seen to be negatively impacted through a range of poor working conditions. Both women
315 and migrant workers are acknowledged to be disproportionately impacted. Elaborating on the
316 impacts trade liberalization on women’s health (in the context of labour markets), are four
317 frameworks, those by: Doyal²⁹, Grown¹⁸, Yaşar³⁷ and Loewenson and colleagues⁴⁷. These frameworks
318 incorporate liberalizing pathways within broader frameworks of globalization, Grown¹⁸ however,
319 specifically focuses on the pathways between trade liberalization and women’s reproductive health.

320 Grown¹⁸ highlights that “[t]rade liberalization can occur through an autonomous decision of a
321 government to remove or reduce barrier to exports, eliminate subsidies to domestic industries and
322 firms, and privatize goods and services, all of which are intended to result in the freer movement of
323 capital, goods, and labor across borders” (p. 29). Grown also highlights that “trade liberalization more
324 commonly occurs as a result of multilateral trade negotiations of the WTO, through regional or
325 bilateral trade agreements, or via conditions attached to IMF or World Bank loans” (p. 29). This latter
326 contextualization of trade liberalization is shared by the other authors, who also emphasize the
327 particular roles of neoliberalism and corporate power in shaping negotiations and agreements. All of
328 these frameworks also acknowledge that women’s employment has increased as a result of
329 globalization. Grown notes liberalization’s specific role in this trend and distinguishes between the
330 growth in women’s share of employment in semi-industrialized countries, those which are
331 agriculturally-oriented and those which are oriented toward the service sector.

332 The author highlights that “[b]oth increased foreign investment and elimination of export tariffs
333 have increased the demand for female labour and provided women access to manufacturing,
334 services, and some types of agricultural employment in many countries” (p. 36). In semi-
335 industrialized countries, women’s work has increased in export oriented industries. It is noted
336 however, that once “these economies mature, the process of feminization of export employment may

337 decline or even reverse" (p. 36). The promotion of cash crops as a liberalization strategy in
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339 agriculturally-oriented economies is seen to have increased women's work as "seasonal, contract
340 workers or as labourers on husbands' or relatives' land" (p. 36). Finally, women are seen to constitute
341 a large share of export workers in economies which emphasize service exports, such as informatics
342 and tourism. Within these different contexts women are found to be at greater risk of sexual activity
343 and sexual harassment. The stress women experience is also seen to be high in these work
environments, which can affect their reproductive health.

344 Finally, child labour is a less explored pathway through which trade liberalization is discussed to
345 impact health in the context of labour markets. Polakoff²⁵ conceptualizes liberalization as a central
346 component of economic globalization which is related to greater world hunger, unemployment,
347 environmental degradation, social fragmentation, and severe crises. These conditions in turn are
348 noted to have "increased exploitation of, and dependence on, child labor" (p. 263). Poor working
349 conditions, including physical abuse and the trafficking of children for sex work, represent the main
350 pathways to health.

351 **4. Discussion**
352

353 The results of this review indicate that early frameworks establishing the link between
354 globalization and health identify important aspects of globalization that shape the context within
355 which trade liberalization is pursued, adopted and responded to. While these early frameworks tend
356 to provide very general pathways between liberalization and health, their strength lies in their ability
357 to contextualize liberalization within broader socio-political contexts and processes. More recent
358 frameworks have begun to account for more specific pathways. This review identified four, non-
359 mutually exclusive contexts through which trade liberalization is understood to impact health:
360 increased flows of goods and people, agricultural and food trade, SAPs, and labour markets.
361 Categorizing pathways across these contexts provided a conceptually useful way of both discussing
362 the vast majority of frameworks and exposing interrelationships and cross-cutting issues across
363 different research areas. In the remainder of this section, two key cross-cutting issues will be
364 discussed which may enable better assessment of the potential impact of liberalization on health,

365 particularly in reference to SDH. Some general considerations are also raised that should be taken

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366 into account if a clearer picture of trade liberalization and its impacts on health is to be achieved.

367 The first cross-cutting issue is that most frameworks included in this review conceptualize trade

368 liberalization in the context of globalization and by referring to ideas like 'market integration' or

369 'openness', or by referencing increased trade flows. Explicit definitions of trade liberalization, by

370 contrast, are largely lacking. This should not be taken as a weakness of individual studies, as the

371 intention of included frameworks was often wider than isolating the specific impact of trade

372 liberalization. Nonetheless, this finding does speak to the wider state of the literature surrounding

373 trade liberalization's impact on health.

374 This work critically appraised studies on their ability to answer the three main questions of this

375 review. In the absence of concrete definitions of trade liberalization, the ability of included studies to

376 do this is significantly limited. This is because drawing on terms which themselves are vague and

377 undefined makes it difficult to distinguish between pathways to health which are understood to

378 originate from trade liberalization specifically and those which are seen to originate from other

379 globalization processes in general. Moreover, the particular role of trade liberalization in these

380 notions is unclear. Openness can broadly refer to deregulation policies or it can be used to indicate a

381 country's degree of integration with global economic forces. This latter notion of openness however,

382 may depend on factors unrelated to trade liberalization, such as countries' natural resource

383 endowments⁵⁸. Moreover, authors using trade flows as a proxy for trade liberalization confuse the

384 processes of trade liberalization with its presumed outcomes. This is especially problematic given the

385 recognition that trade liberalization does not inevitably lead to increased flows⁵⁹.

386 On its face, trade liberalization may seem rather simple to define, however, this review

387 demonstrates the difficulty in doing so. For example, while many framework authors conceptualize

388 financial liberalization as a central component of trade liberalization, others see it as a distinct

389 process. Moreover, export support policies, including currency devaluation, are sometimes identified

390 as important components of trade liberalization²⁰.

391 While the variety of discussed liberalization processes begin to paint a more comprehensive

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392 picture of trade liberalization as it relates to health, it also exposes a lack of consensus on what

393 exactly the concept of liberalization refers to. The need for consensus in this regard is articulated by

394 Starfield⁶⁰ who argues that “common definitions of concepts are necessary in order for researchers

395 to develop common measures, whether in descriptive, analytic, pathway, or intervention studies. The

396 absence of a common definition will make it difficult if not impossible to draw any conclusions about

397 the policy implications of the findings of research” (p. 552).

398 In synthesizing researchers’ different conceptualizations of trade liberalization, this review

399 underscores that trade liberalization is a multi-faceted concept, shaped by neoliberalism,

400 characterized by unequal power relations and promoted through a range of institutions, agreements

401 and policies in the domains of goods, services and investment. To make clear theorized pathways to

402 health, in future work, researchers should be explicit about how they are conceptualizing

403 liberalization. Recent work providing critical treatments of neoliberalism⁶¹ and power relations⁶² in

404 the context of trade-related issues may prove useful in this regard. In order to comprehensively

405 explore the health impact of liberalizing processes and draw more informed conclusions about their

406 combined impact on health, future work should also seek to establish a common definition of trade

407 liberalization. Findings from this review indicate that definitions of trade liberalization should not

408 equate liberalizing policies to increased trade flows or other measures which can conflate

409 liberalization for its presumed outcomes.

410 The second cross-cutting issue relates to representations of SDH across frameworks. Notably, a

411 range of SDH were identified across the four contexts, most often in relation to labour markets and

412 SAPs, and to a lesser extent in relation to agricultural and food trade, and flows of goods and people.

413 The SDH given the greatest attention were those that relate to income and employment. In the

414 context of agricultural and food trade for example, import liberalization is seen to negatively affect

415 the livelihood of agricultural producers in developing countries. In the context of SAPs, liberalization

416 is related to increased unemployment, poverty and income inequality, deteriorating living conditions,

417 and reductions in household income. In the context of labour markets, of fundamental concern are

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418 employment, wages and working conditions.

419 This review identified only one framework, by Blouin and colleagues⁸, which sought to expose
420 the exclusive impact of trade liberalization on a range of SDH. Findings from this review build on this
421 work by indicating the different contexts through which trade liberalization may impact SDH. Under-
422 developed conceptualizations of trade liberalization however, were found to be especially prevalent
423 in terms of SDH pathways. This means that there is a less clear picture of how SDH are impacted by
424 liberalization than is the case for other health determinants, such as food or tobacco.

425 Together these issues support a recent call for a more focused and theoretically informed
426 research agenda on trade as it relates to SDH⁸. Findings from this review provide a starting point for
427 thinking about the different contexts through which liberalization processes might impact SDH and
428 some of the different liberalizing policies which may be important to consider. An important
429 consideration which can be drawn from work in the area of SAPs is that processes of trade
430 liberalization can take place outside the specific context of free trade agreements.

431 In developing our understanding of trade liberalization's impact on SDH, it is also critical to
432 recognize the role of social policies. Social policies can contribute directly to SDH through transfers
433 and services, like unemployment insurance and pensions, and indirectly, for example, by influencing
434 labour market opportunities. The implication here is tri-fold. First, liberalization may have important
435 impacts on countries' ability to provide social protection²⁴. This is because liberalization may reduce
436 both governments' tax revenues, an important source of social policy funding, especially in LMICs,
437 and countries' policy space (i.e. their freedom to "choose, design, and implement public policies to
438 fulfill their aims" (p. 105)⁶³). This latter process is especially important to consider in the current
439 context of increasing bilateral and regional trade agreements, which go beyond WTO requirements
440 to influence countries' domestic policies^{63,64}. Second, social policies may have a moderating effect on
441 liberalizing pathways to health^{8,24}. Social policies related to unemployment compensation for
442 example, may moderate or exacerbate the effects of trade liberalization on health outcomes⁶⁵. Third,
443 social policies may influence the type of health-related pathways resulting from trade liberalization,

444 for instance, through labour market regulations⁶⁵. As an example, employment protection
445 regulations may determine how firms can respond to the pressure of increased competition. In one
446 country, firms may be able to freely dismiss workers, while in another they may be required to first
447 reduce working hours. Each of these measures would have different implications for health. Overall,
448 this means that pathways from liberalization to SDH depend not just on the characteristics of trade
449 policies, but also on the characteristics of states' social policies. Recent empirical work has
450 demonstrated the utility of incorporating considerations of how trade and social policies interact⁶⁵,
451 an issue which received scant attention by frameworks included in this review. Future work may
452 therefore also find it useful to further engage with social epidemiological, as well as sociological,
453 theories which consider how social policies translate into health distributions⁶⁶.

454 Engaging with these different literature bases may also help to address a limitation found in
455 relation to frameworks' conceptualizations of health. Frameworks were almost equally split between
456 investigating health and health inequalities/inequities. Those investigating health differences were
457 more likely to contextualize trade liberalization with references to power imbalances and by
458 considering the role of neoliberalism as an ideological force driving the processes of trade
459 liberalization. Outside of this distinction however, it wasn't readily apparent how pathways leading
460 to health and health differences differ, a distinction which is both recognized elsewhere and
461 currently receiving greater theoretical consideration^{60,66,67}.

462 Finally, in addition to the above concerns, this review identifies some general considerations
463 that should be taken into account if a clearer picture of trade liberalization and its impacts on health
464 is to be achieved. These relate to the fact that trade liberalization policies undertaken in one country
465 can have important impacts on others, that liberalizing policies can have differential impacts both
466 between and within countries, and that liberalization is often a self-reinforcing trend⁶⁸. While these
467 issues may seem obvious, they are important to highlight because some frameworks 'disembed' their
468 conceptualizations of liberalization from global interactions and instead focus on the domestic health
469 impact of national liberalization processes. Moreover, many frameworks fail to account for the fact
470 that impacts can depend on countries' positions in production-consumption chains^{14,69} or on the

471 structure of their labour market¹⁸. The poor, women, children, and immigrants are also consistently
 472 identified as vulnerable population subgroups, though these differential impacts are not always
 473 acknowledged. In the absence of these considerations, the health impacts of liberalization policies
 474 are likely to be at best, mis-specified, and at worst, vastly under-estimated.

475 **Conclusion**

476 This review identified four main contexts through which liberalization may impact health:
 477 increased flows of goods and people, agricultural and food trade, SAPs, and labour markets.
 478 Pathways identified within these contexts seem to offer only a partial glimpse of a conceivably much
 479 larger trade liberalization and health agenda. Two major limitations of the literature are the lack a
 480 common understanding of what trade liberalization actually refers to and under-developed
 481 conceptualizations of how liberalization impacts SDH. Future work should be explicit about how
 482 trade liberalization is being conceptualized and efforts should be undertaken to develop a common
 483 definition. A more focused research agenda is recommended which takes SDH into greater account
 484 by considering the role of social policies and theoretical developments in social epidemiological and
 485 sociological literature. Findings indicate that future work should also account for how liberalizing
 486 pathways to health and health differences differ and for the differential impact of liberalizing policies
 487 across countries with different levels of development, different structures of labour markets and
 488 different positions in production-consumption chains. Within countries, health impacts should
 489 especially be considered in terms of vulnerable population groups.

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648 **Figure 1** Identification and selection process

649 **Figure 2** Globalization and Health: a framework for analysis and action (Woodward et al. 2001 p.877)

650 **Figure 3** Globalization and Health: a framework for analysis and action (in detail) (Woodward et al.
651 2001 p.878)

652 **Figure 4** Framework for Analyzing the Links Between Globalization and Health (Labonté and
653 Torgerson 2003 p.13)

654 **Figure 5** The health impacts of globalisation: a conceptual framework (Huynen et al. 2005a p.3)

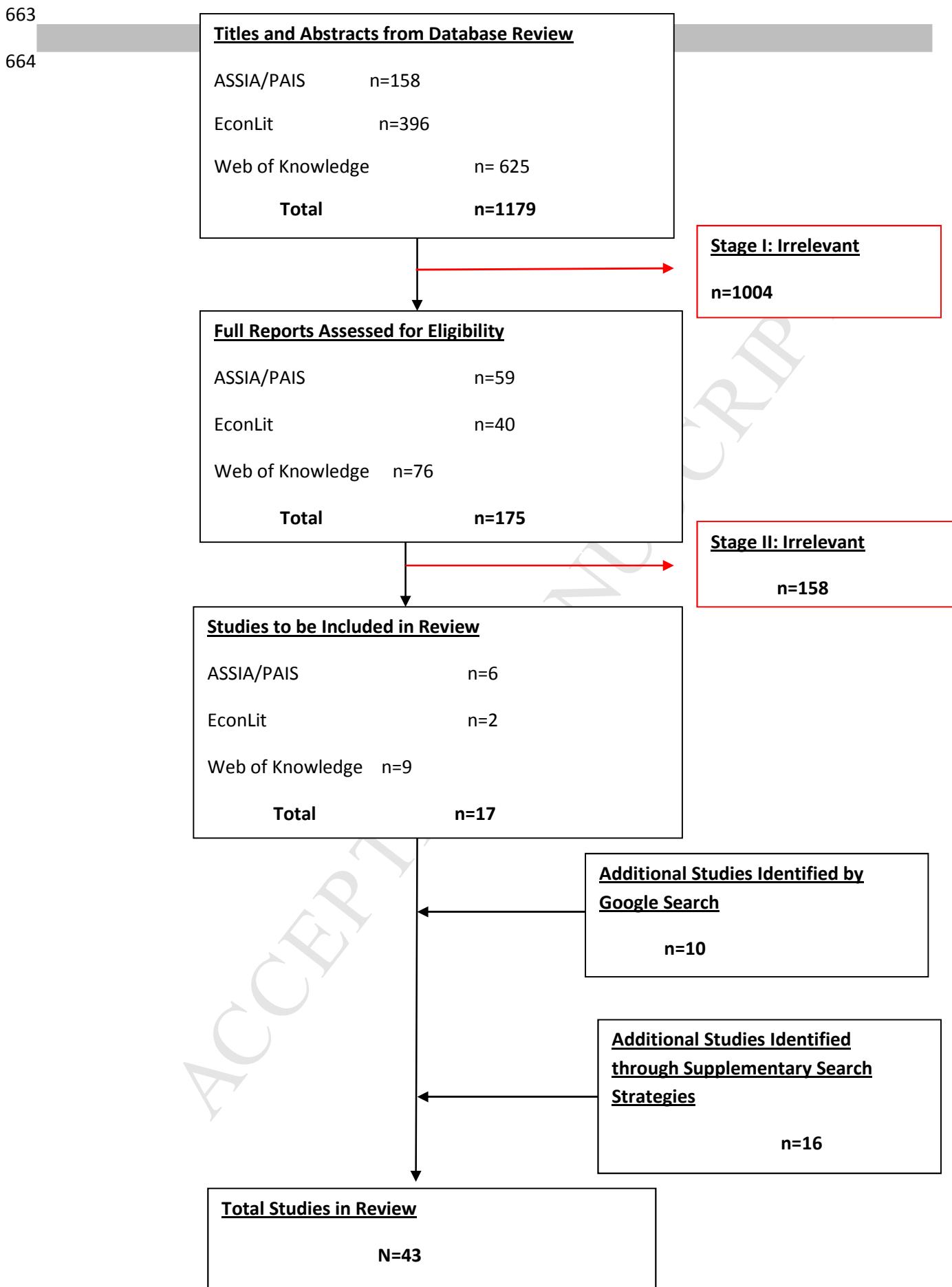
655 **Figure 6** The health impacts of globalisation: a conceptual framework (in detail) (Huynen et al. 2005a
656 p.5)

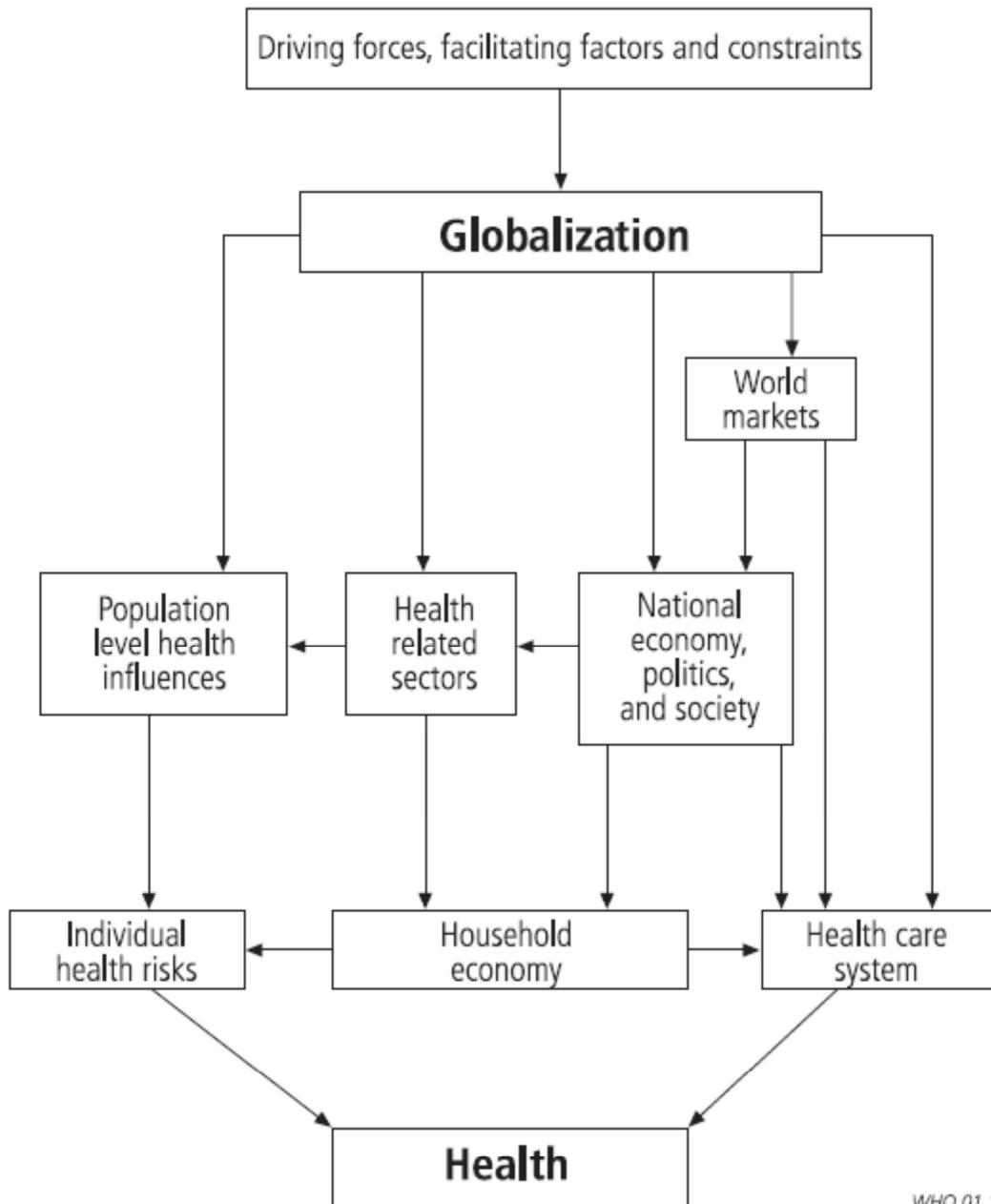
657 **Figure 1** Towards Health-Equitable Globalisation: Rights, Regulation and Redistribution (Labonté et al.
658 2007 p.18)

659 **Figure 8** Towards Health-Equitable Globalisation: Rights, Regulation and Redistribution (Labonté et al.
660 2007 p.87)

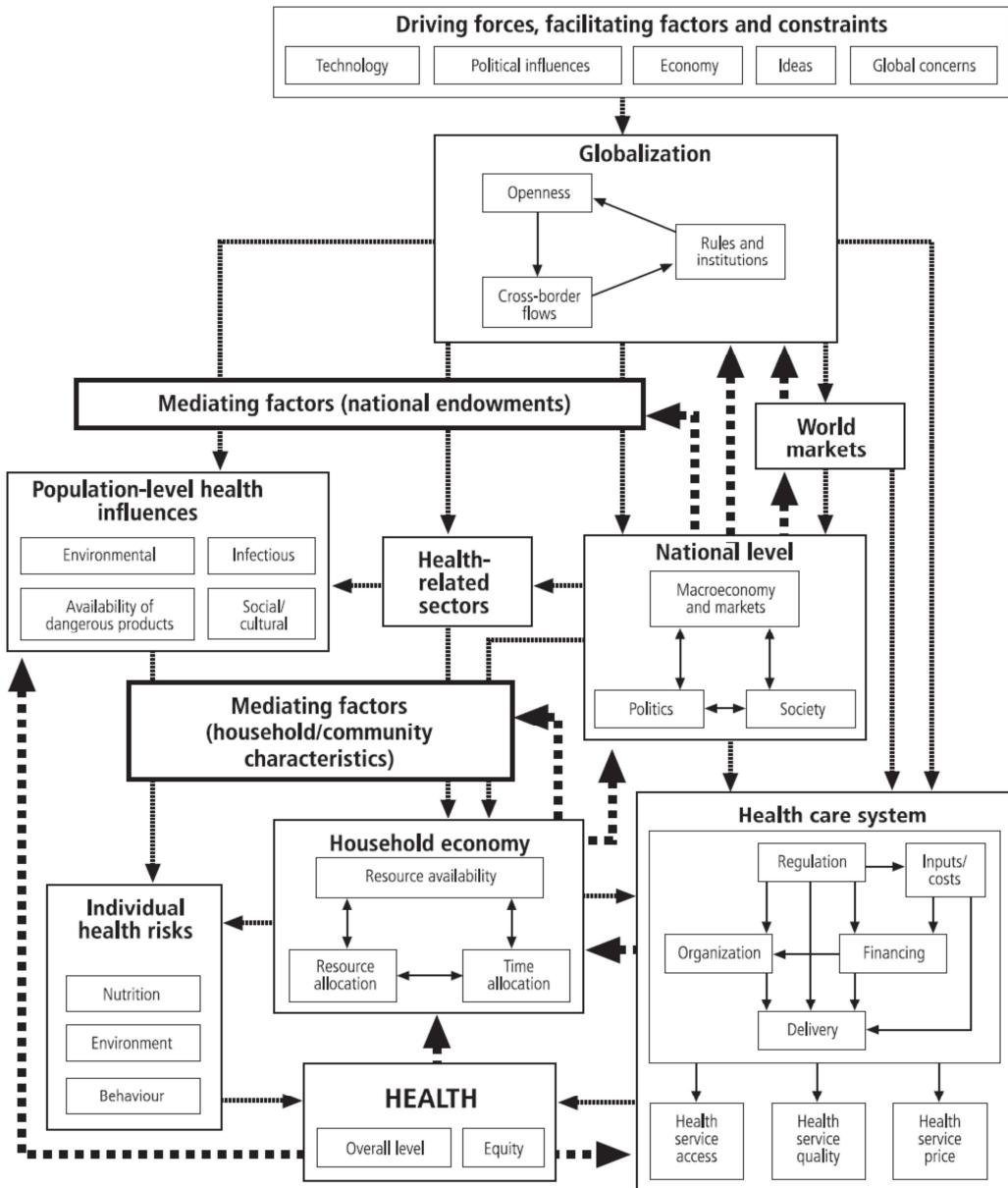
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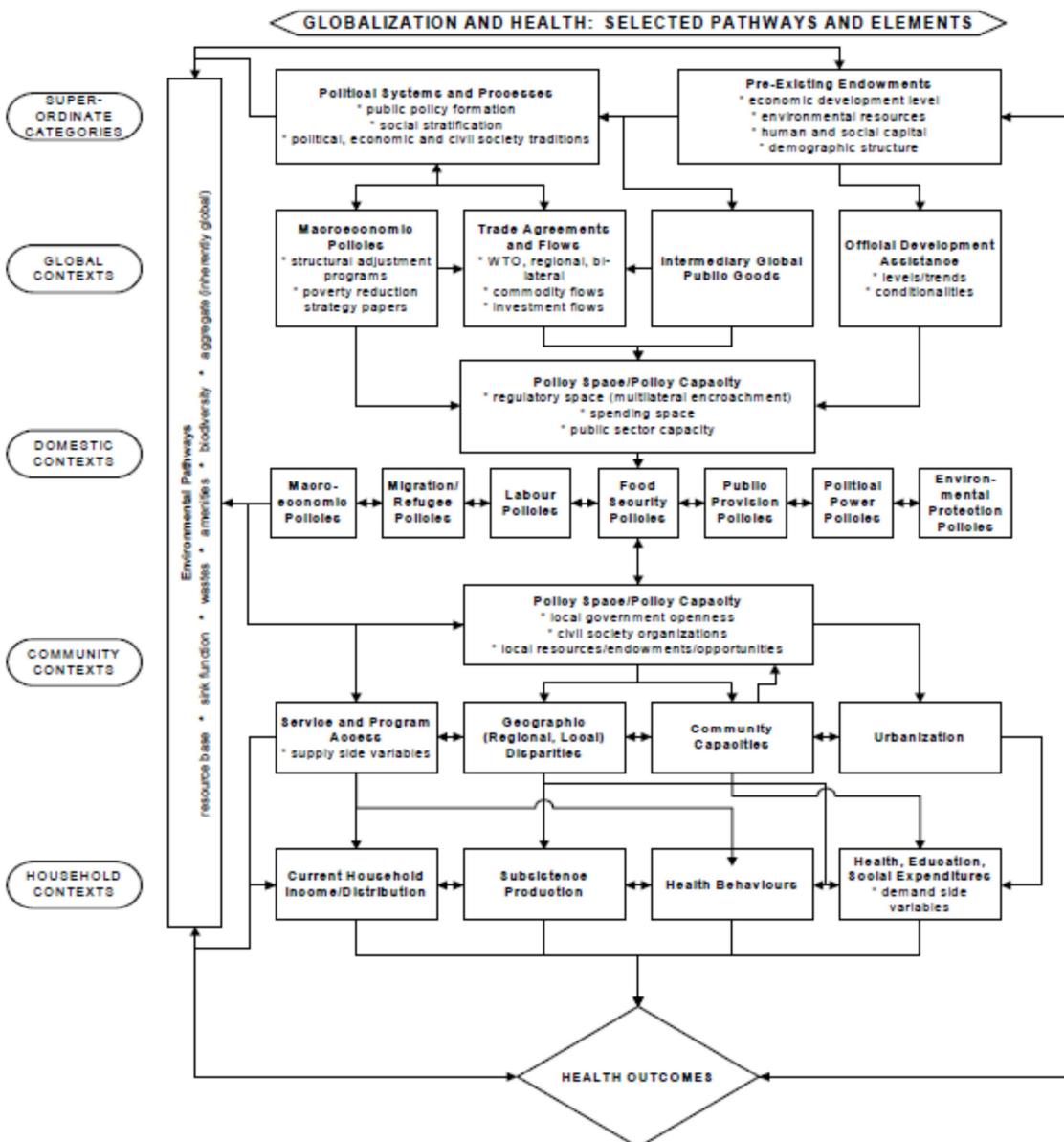
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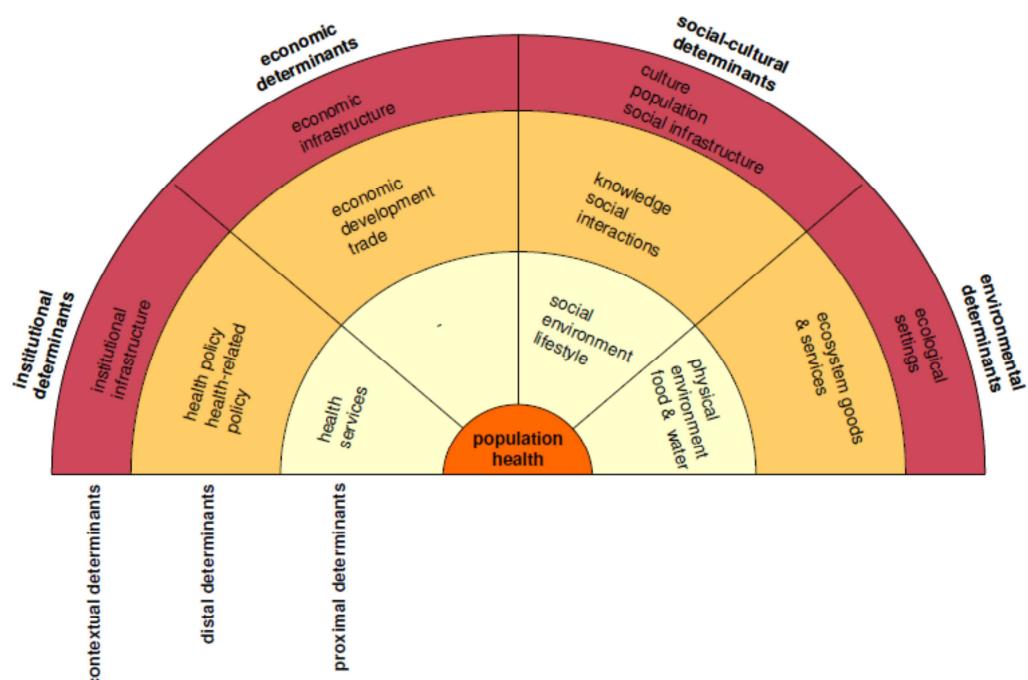
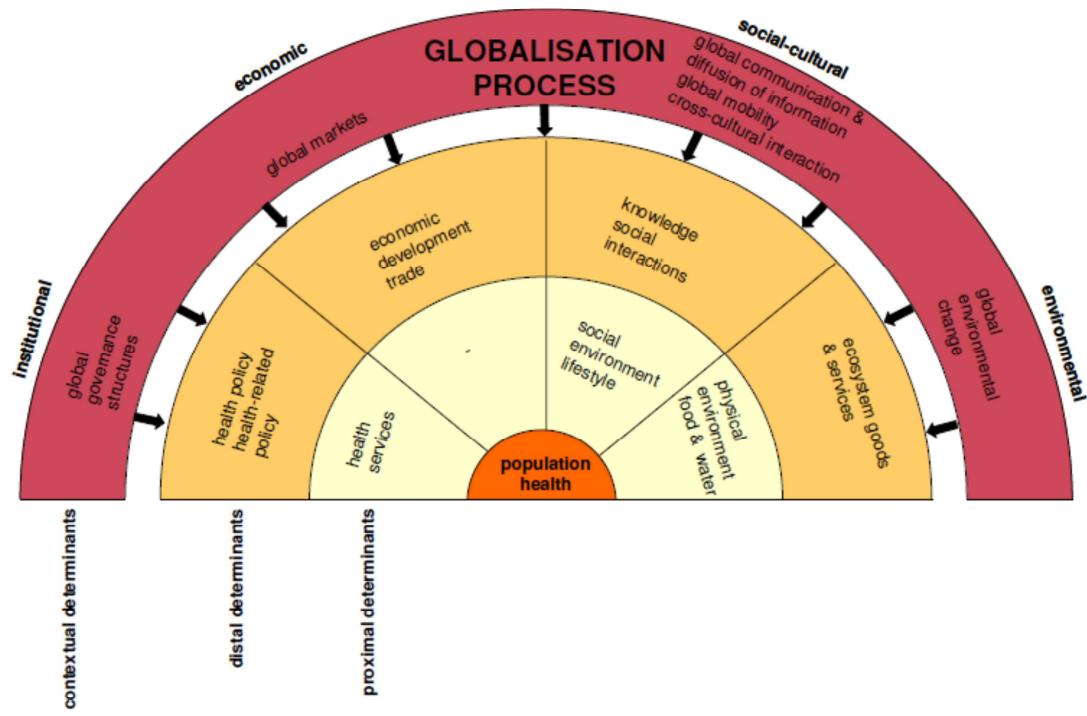


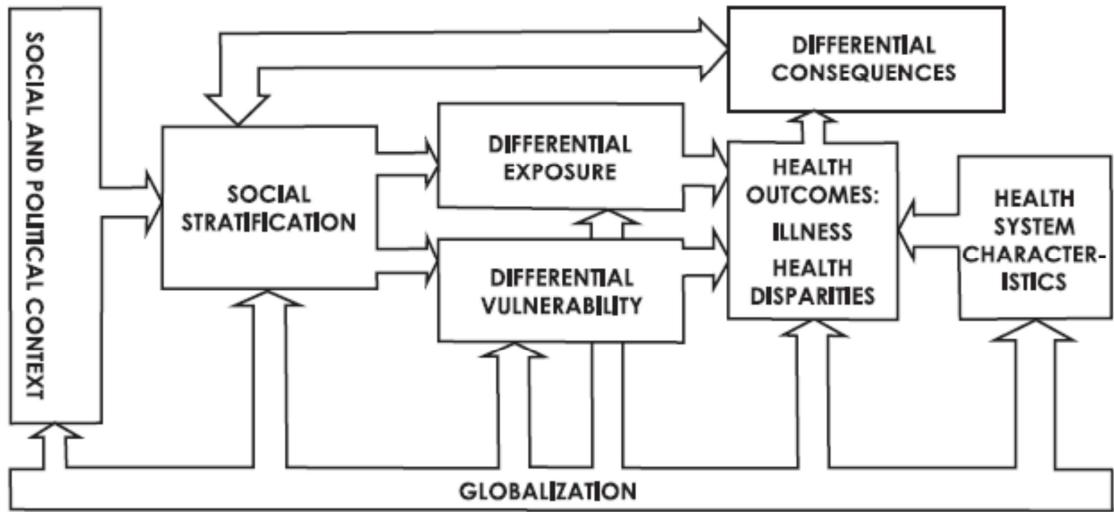


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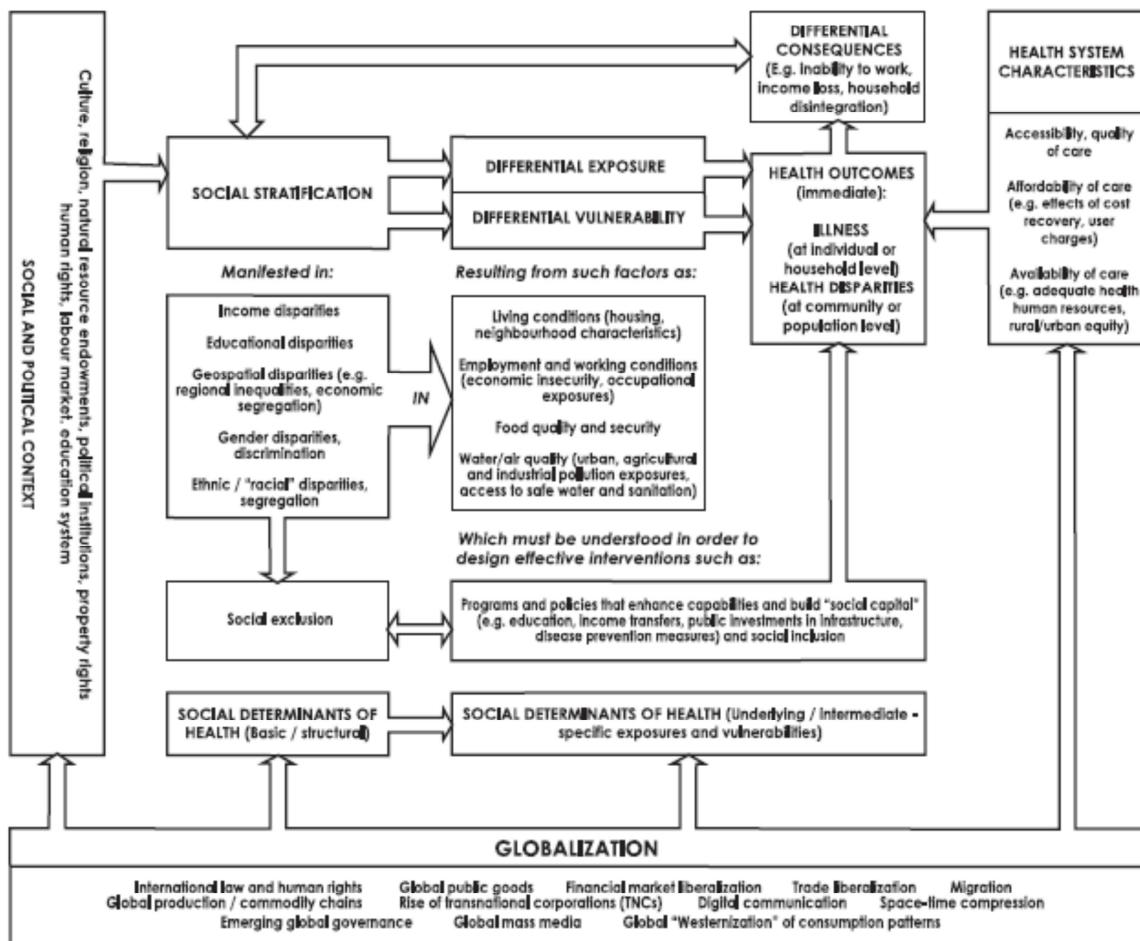








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| Author | Explicit definition of trade liberalization |
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| Grown (2005) | "the progressive reduction of barriers to imports and exports" (p. 28) |
| Hawkes (2006) | "increasing market-orientation" (definition for the 'degree of liberalization') (p. 3) |
| Labonté and Torgerson (2005) | "the removal of border barriers, such as tariffs, on the flow of goods and capital" (p. 161) |
| Labonté et al. (2011) | "eliminating quotas, reducing tariffs, and privatizing state trade agencies" (p. 4) |
| Rayner et al. (2006) | "opening up" (p. 67) |
| Thow (2009) | An "integrated global economy" where "the most obvious policy changes relate to reductions in barriers to import of goods (e.g. tariff reduction)", but also including "export promotion, reducing restrictions on company ownership, financial flows and trade in services, implementing customs reforms and laws regarding equality of treatment (both for firms and countries)" (p. 2150-2151) |

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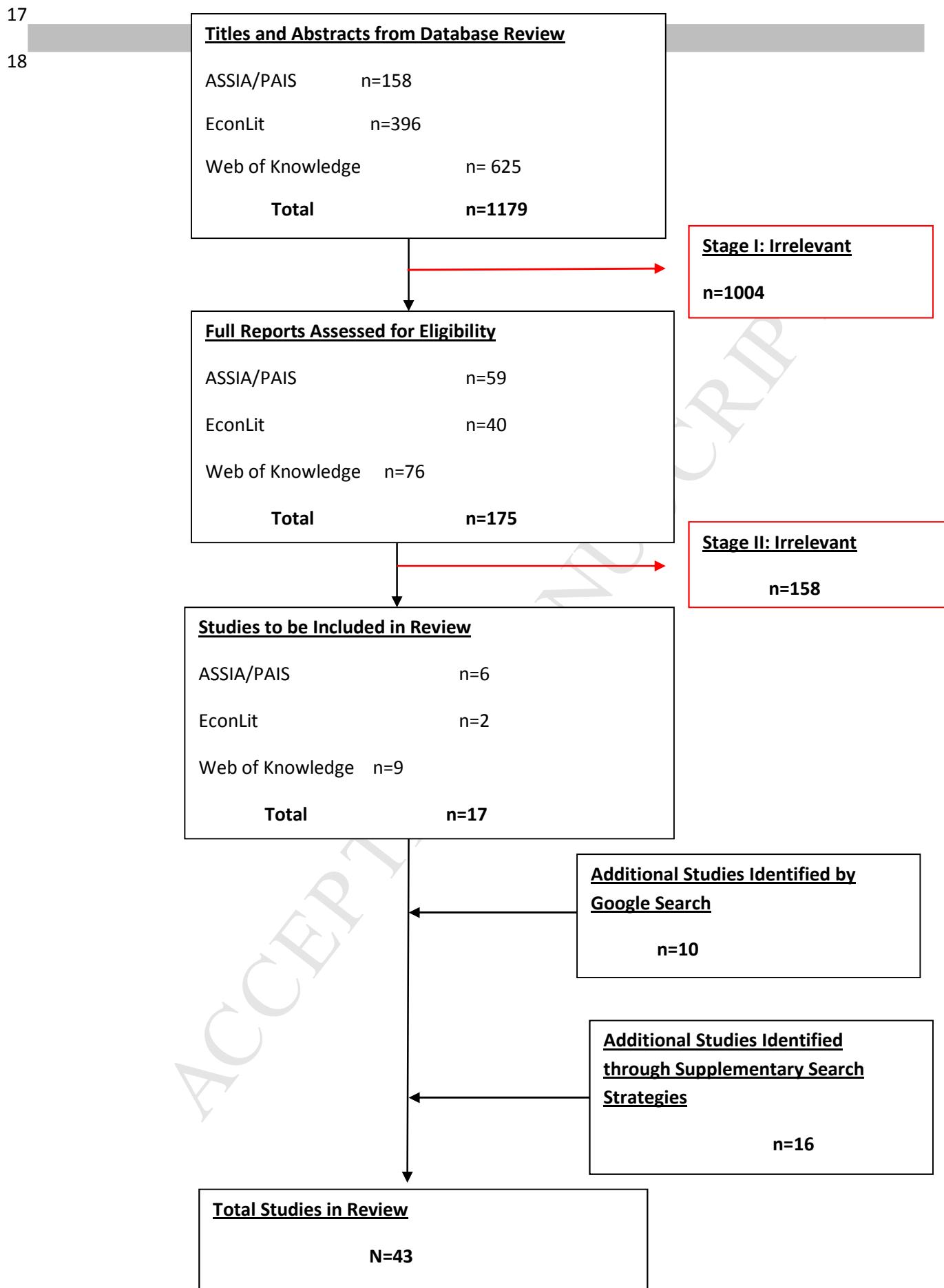
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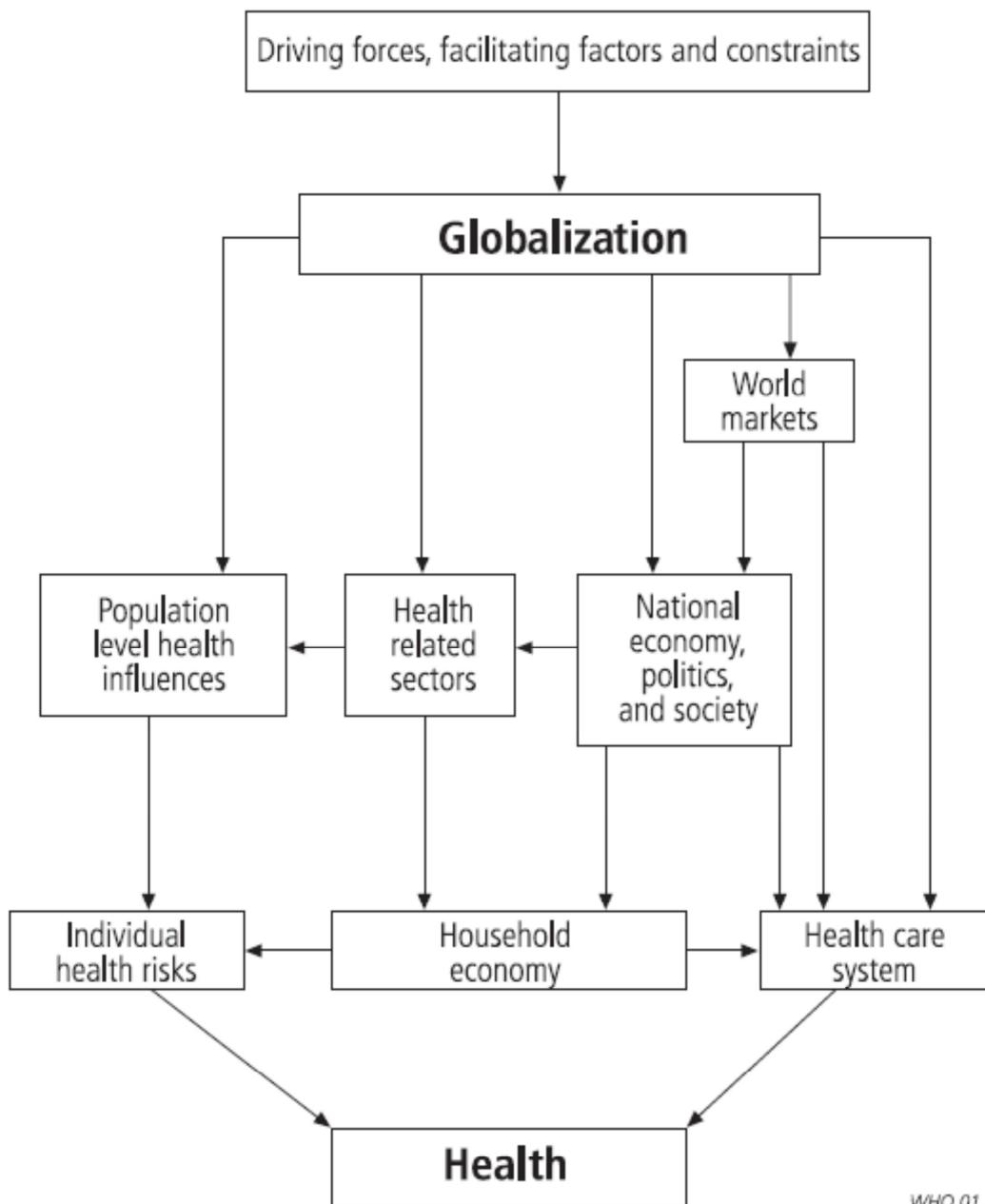
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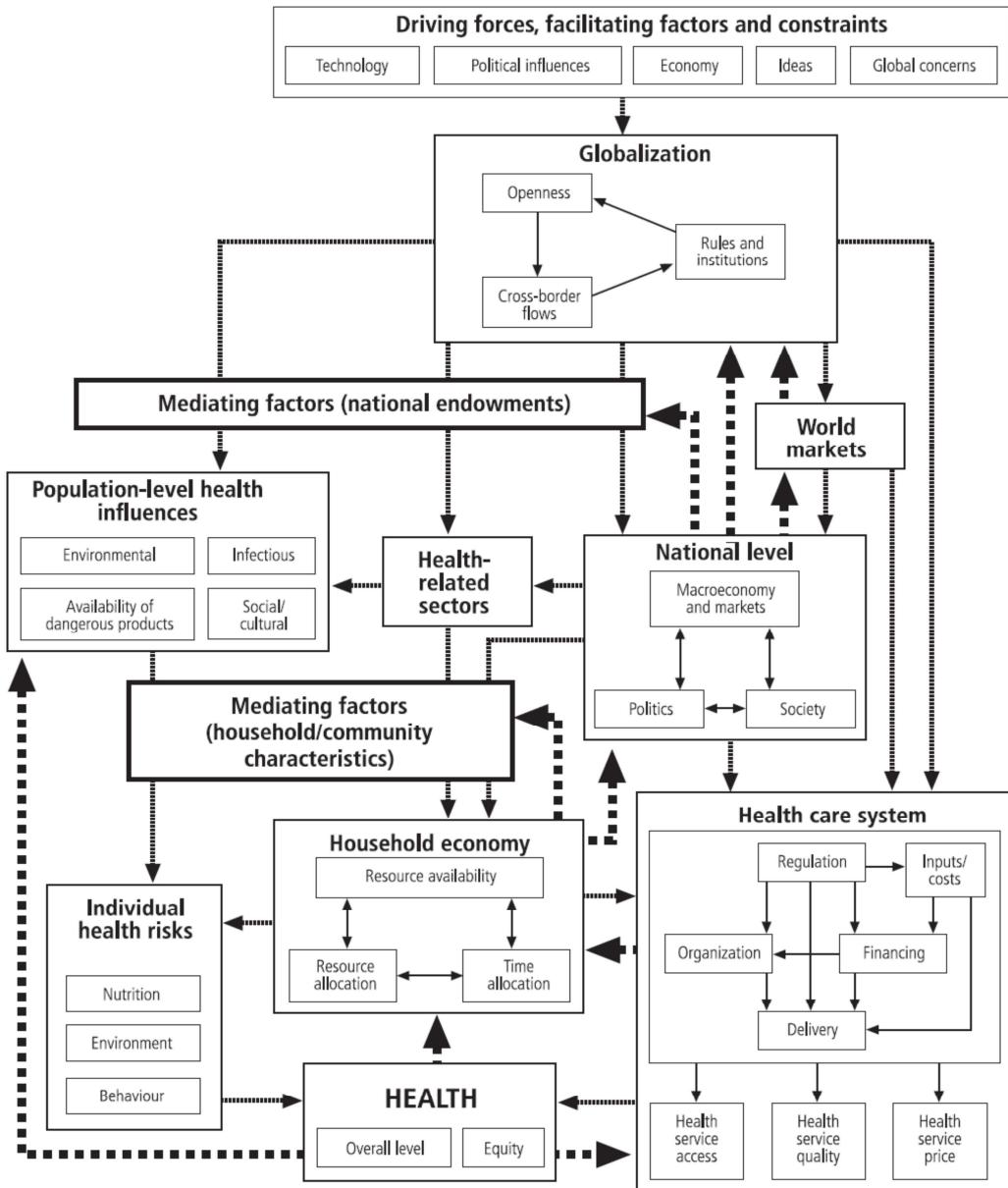
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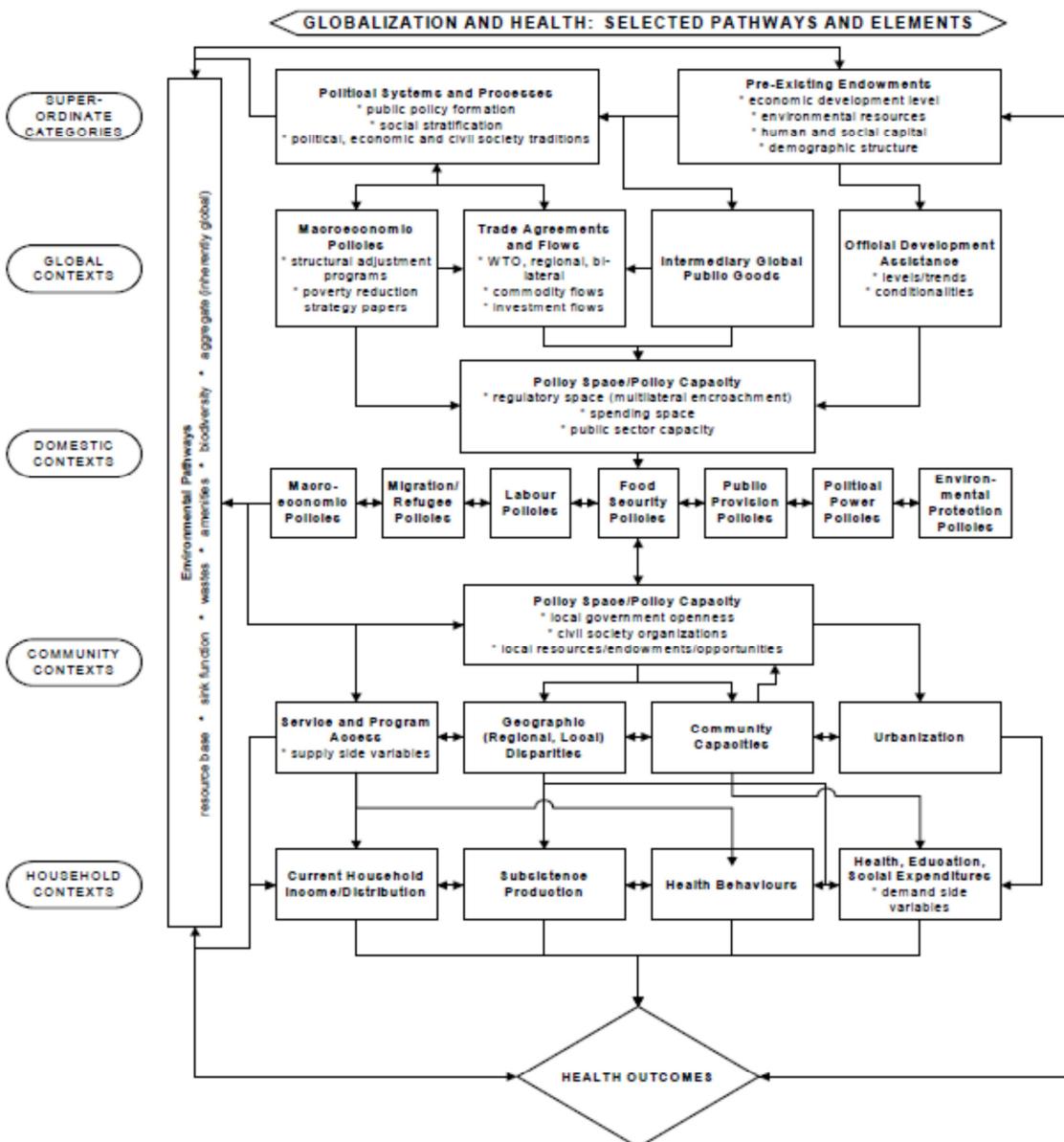
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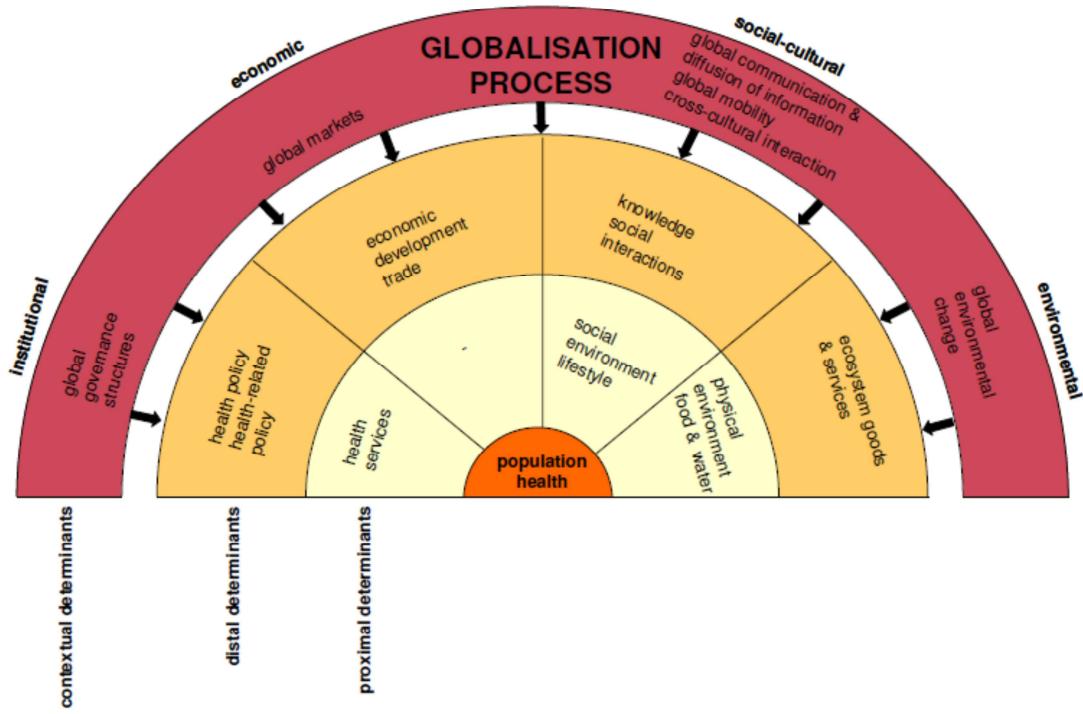




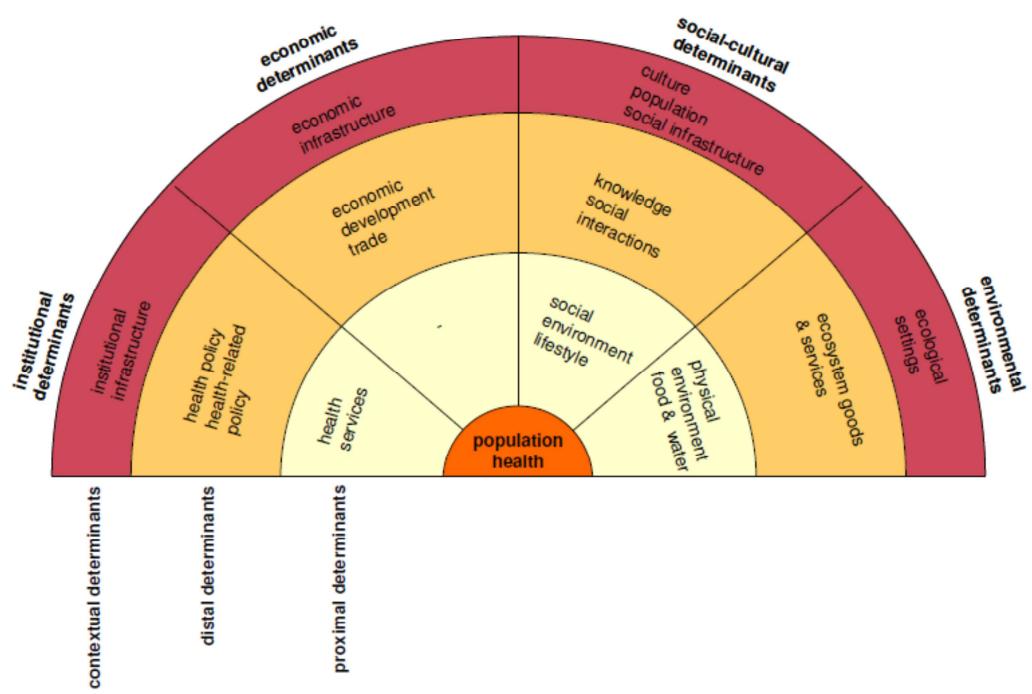
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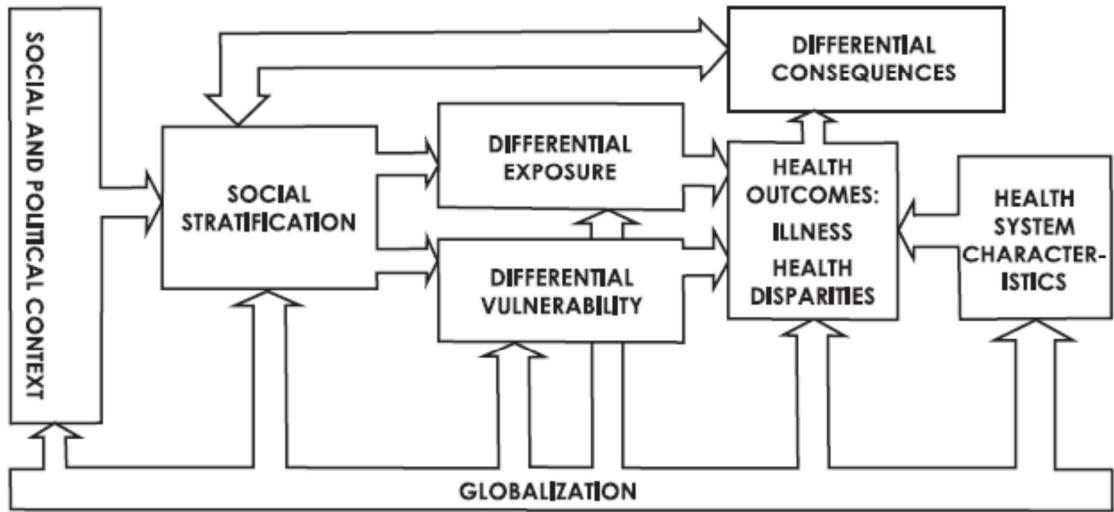




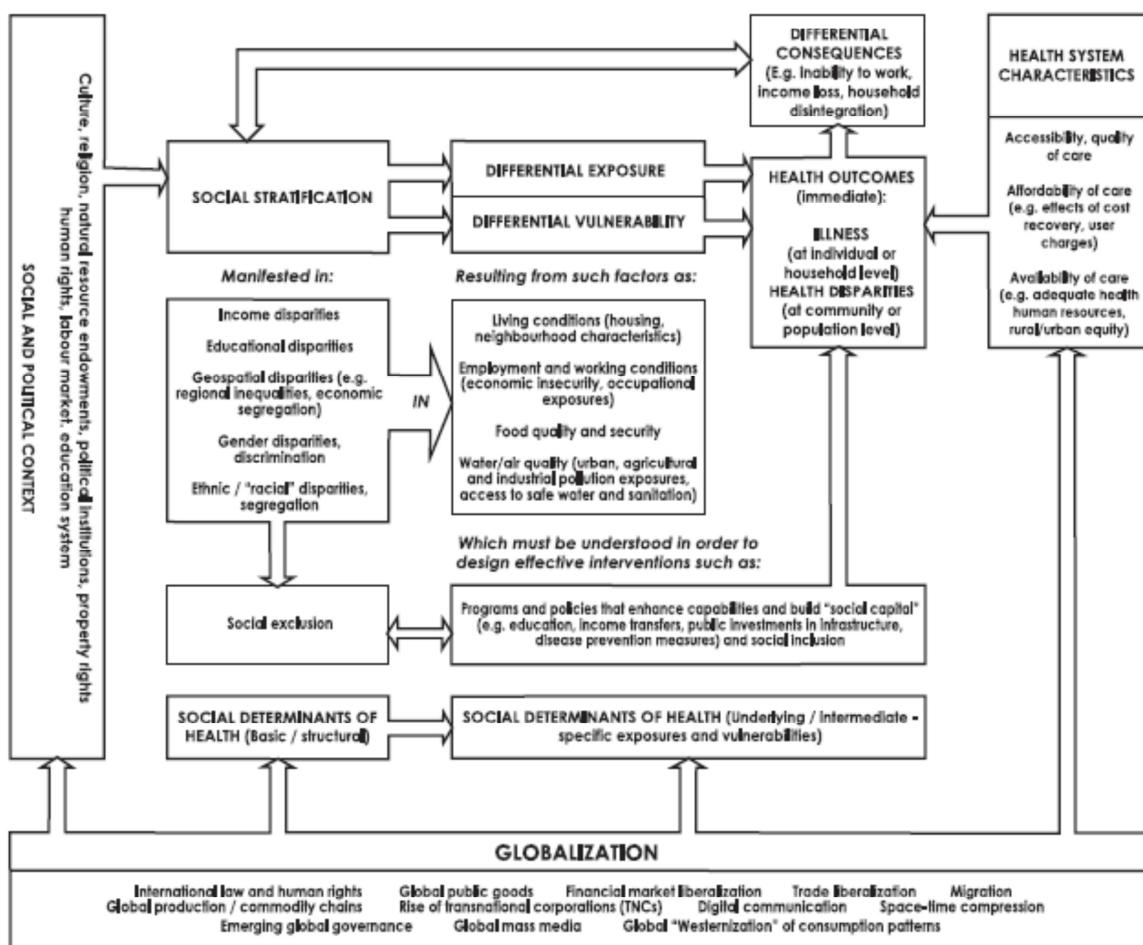
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| Rayner et al. (2006) | "opening up" (p. 67) |
| Thow (2009) | An "integrated global economy" where "the most obvious policy changes relate to reductions in barriers to import of goods (e.g. tariff reduction)", but also including "export promotion, reducing restrictions on company ownership, financial flows and trade in services, implementing customs reforms and laws regarding equality of treatment (both for firms and countries)" (p. 2150-2151) |

- Systematic review of trade liberalization and health frameworks
- Missing is a common understanding of what liberalization actually refers to
- Pathways to health especially underdeveloped in reference to SDH