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Patently obvious: a public health analysis of pharmaceutical industry statements on the Trans-Pacific Partnership international trade agreement

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The Trans-Pacific Partnership Agreement (TPPA) is a regional trade agreement being negotiated by 12 countries, including New Zealand and the United States of America (USA). The patent-holding pharmaceutical industry (the Industry) has lobbied for enhanced intellectual property protections and rules affecting pharmaceutical pricing and reimbursement in the TPPA. These provisions would likely reduce access to affordable medicines. This paper reports on a study exploring how the Industry has used language to frame the TPPA in an effort to influence opinion and exert leverage. We undertook a thematic analysis of the language used in publicly available statements about the TPPA from the Industry's national associations in the USA and New Zealand. Data included press releases, submissions and other statements dated 2008–2013. The Industry framed the TPPA as contributing to the public good. The TPPA was portrayed as redressing inequitable pharmaceutical policies, which limit people's access to new medicines. Further, the TPPA was constructed as the route to economic growth for the USA and ultimately for all TPPA countries, through increased intellectual property protection for the pharmaceutical industry. This framing obscured tensions between Industry interests and public health goals. The Industry remained silent on the issue of affordability, a key dimension of equitable pharmaceutical access. The use of rhetoric, such as 'win-win outcomes' (for TPPA countries and the Industry), hid the vested economic interests of the Industry in the TPPA. Understanding the Industry's framing of issues can assist public health advocates in challenging prevailing discourses and exposing vested interests.

Keywords: New Zealand; USA; international trade agreements and health; access to medicines; public health; policy analysis; pharmaceutical industry

Introduction

This paper presents a critical public health analysis of literature generated by the patent-holding pharmaceutical industry (the Industry) in the United States of America (USA) and New Zealand (NZ) about the Trans Pacific Partnership Agreement (TPPA). We examined the text of publicly available documents (November 2008–March 2013) produced by Pharmaceutical Research and Manufacturers of America (PhRMA) and Medicines New Zealand (MNZ); the national associations representing patent-holding pharmaceutical companies (the Industry) in the USA and NZ, respectively. Our aim

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was to explore how the Industry has used language to attempt to shape public debate and the direction of the TPPA negotiations.

The TPPA and the pharmaceutical industry

During domestic public consultation processes prior to the commencement of TPPA negotiations in both the USA and NZ, submissions by pharmaceutical industry associations (Pharmaceutical Research & Manufacturers of America, 2009; Researched Medicines Industry Association of New Zealand Incorporated, 2008) indicated that the TPPA was seen by the Industry as a vehicle for enhancing its intellectual property (IP) rights in the participating countries. These submissions were greeted with concern by international health, development and consumer non-governmental organisations and academics (Faunce & Townsend, 2010, 2011).

The World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), which came into force in 1995, set new global norms for IP protection, including 20-year patent terms (Smith, Correa, & Oh, 2009). The period since this Agreement has seen, with a few exceptions, an 'upward ratchet' in IP rights through bilateral and regional trade agreements negotiated by the USA and the European Union (Sell, 2007). Recently, the USA has also introduced provisions pertaining to pharmaceutical pricing and reimbursement into its trade agreements with countries that have national pharmaceutical coverage programs, including Australia and South Korea (Lopert & Gleeson, 2013).

Negotiating documents leaked in 2011 (Trans Pacific Partnership, 2011a, 2011b) indicate that the USA sought more extensive protections for IP in the TPPA negotiations than those seen in previous trade agreements. The Office of the US Trade Representative (USTR) also drafted a TPPA annex (Trans Pacific Partnership, 2011c) pertaining to pharmaceutical coverage programs that would undermine reference pricing, increase industry influence over pharmaceutical decision-making and legalise direct-to-consumer advertising of prescription drugs via the internet (Gleeson, Lopert, & Reid, 2013; Lopert & Gleeson, 2013).

International health and development NGOs criticised these proposals for their potential to lengthen and broaden patent monopolies and delay the entry of cheaper generic drugs in the TPPA countries (Medecins Sans Frontieres, 2012; Oxfam America, 2011). Subsequent leaks of negotiating documents (Trans Pacific Partnership, 2013, 2014) indicate that the USA has continued to pursue extensive IP protection in the face of opposition from the other countries.

Pharmaceutical industry influence on the TPPA negotiations

The pharmaceutical industry has played a key role in the development of the United States position on pharmaceuticals in the TPPA negotiations. Firstly, Industry representatives move in and out of the Office of the USTR (Program on Information Justice and Intellectual Property n.d.; Sell, Fattahi, & Palmedo, 2011). They have direct input to draft text through several Industry Trade Advisory Committees (Lopert & Gleeson, 2013). Pharmaceutical companies and their national association, PhRMA, have lobbied the USTR and the US Government in pursuit of more favourable market conditions in the TPPA countries (see http://sunlightfoundation.com/blog/2014/03/13/tpp-lobby/). PhRMA has also sought to influence public opinion through letters, speeches, articles, blog posts and opinion pieces.

Similarly, in New Zealand, the national association representing patent-holding pharmaceutical companies, Medicines New Zealand (formerly the Researched Medicines Industry Association or RMI), has made submissions, lobbied the New Zealand Government and sought to influence public opinion. New Zealand, in contrast to the USA, does not have a domestic research-based pharmaceutical industry. The only pharmaceutical company manufacturing prescription drugs in New Zealand produces generic medicines. MNZ's membership is made up of businesses registered in New Zealand; however, these businesses are affiliated to, or subsidiaries of, transnational pharmaceutical corporations. At the time of writing, at least 12 of MNZ's 19 full-member organisations were affiliated with corporations that were also members of PhRMA.

The USA, home to a large number of pharmaceutical companies, largely sets the agenda for the TPPA negotiations. New Zealand is likely to be one of the countries for which the Industry most hopes to obtain improved market access. NZ currently has relatively low-level IP protection for a developed country by international standards (Kilic & Maybarduk, 2012). Its Pharmaceutical Management Agency, PHARMAC, is internationally renowned for its ability to contain pharmaceutical costs while enabling access to essential medicines and value for money (Gleeson et al., 2013). The Industry has long criticised the 'climate for innovative medicines in New Zealand' as well as the transparency and fairness of PHARMAC's processes (Kirk, 2012).

While New Zealand is a small market for the US pharmaceutical industry, PHARMAC has global significance as its high degree of control over prices (Gleeson et al., 2013) makes it an attractive model for other nations. Since its establishment in 1993, PHARMAC has effectively contained costs while increasing the number of medicines subsidised (Ragupathy, Aaltonen, Tordoff, Norris, & Reith, 2012) due to its capped budget and its purchasing strategies, such as sole-supplier tendering (PHARMAC, 2013b). In its annual report to government, PHARMAC reported a saving to regional health care-funding bodies (District Health Boards) of $3.8 billion NZ dollars between 2002 and 2012 (PHARMAC, 2013a). In light of this significant cost-saving, the Industry has an incentive to curtail PHARMAC's effectiveness and prevent the wider adoption of the PHARMAC model.

Access to medicines – a public health perspective

Access to health care services is a key social determinant of health (CSDH, 2008), and includes access to therapeutic interventions such as pharmaceuticals. Cost is a crucial access factor and influences health equity. Access to affordable essential medicines is a problem for both developing countries and for disadvantaged groups in developed countries, and the TPPA may worsen inequities in both contexts. The TPPA includes both developing countries such as Vietnam, Peru and Malaysia, and wealthy countries, such as the USA, Canada and Australia.

In developing countries, millions of people lack access to medicines. For example, only 61% of people living with HIV in low- and middle-income countries who were eligible for treatment under 2010 WHO guidelines had access to it in 2012 (UNAIDS, 2013, p. 6). Medicine affordability is a major problem in Vietnam, the lowest income TPPA country. Nguyen, Knight, Mant, Cao, and Auton (2009, p. 6) found that in Vietnam in 2005, 'Medicines were unaffordable for the lowest paid unskilled government worker, thus being unaffordable for the large percentage of the population who earn less than this benchmark'. A recent modelling study found that the 2014 United States proposals for the TPPA could reduce HIV treatment coverage from 68% to 30%

of eligible patients in Vietnam, assuming the current budget for treatment remains unchanged (Moir, Tenni, Gleeson, & Lopert, 2014).

While access to medicines in developed countries is not likely to be affected to the same extent by the TPPA, disadvantaged groups such as people on low incomes are more likely to experience access barriers if medicine costs rise due to the TPPA (Gleeson et al., 2013; Monasterio & Gleeson, 2014). When patient co-payments rise, use of prescription medicines falls, particularly in disadvantaged groups (Kemp et al., 2013; Searles, Doran, Faunce, & Henry, 2013). In New Zealand, individuals from ethnic groups with the lowest life expectancies, Māori and Pacific peoples, report lower rates of filling prescriptions due to cost compared with non-Māori or non-Pacific (Jatrana, Crampton, & Norris, 2011; Ministry of Health, 2013).

Methods

Our research question was: How has the Industry used language and ideas to attempt to influence the TPPA negotiations? To answer this question, we studied publicly available texts produced by associations representing the Industry in the USA and NZ: PhRMA and MNZ. This research drew on a combination of critical discourse analysis (van Dijk, 1993), thematic analysis (Braun & Clarke, 2012) and policy analysis (Bacchi, 1999) approaches to analyse the data.

Sampling

We searched government websites in both countries to locate submissions on the TPPA by the two organisations. Submissions made by PhRMA to the USTR were retrieved from the US Government public website (http://www.regulations.gov). The New Zealand Government's Ministry of Foreign Affairs and Trade website was searched for publicly available submissions by MNZ. PhRMA and MNZ websites were also searched for material relating to the TPPA, using the term 'Trans Pacific Partnership'.

PhRMA and MNZ documents were eligible for inclusion in the sample if they appeared to reflect PhRMA and MNZ's representations of the TPPA to decision-makers and the public. All documents meeting this criterion, dated between November 2008 (date of the first document mentioning the TPPA produced by either organisation) and March 2013 (researchers' deadline), were included in the sample. Initial searches for MNZ documents located only three eligible documents. The search was then widened to include MNZ annual review documents (2010–2012) and a MNZ flyer on the TPPA that had been handed to negotiators and stakeholders at a TPPA negotiating round in December 2012.

Nineteen documents were included in the sample; 12 from PhRMA and 7 from MNZ (see Table 1). Blog posts, speeches and opinion pieces mentioning the TPPA were

Table 1. Sample by document type (Nov/08-March/13).

	PhRMA	Medicines New Zealand (formerly RMI)
Submissions	8	1
Media releases	4	2
Annual reviews	0	3
Flyers	0	1

excluded as they were found to replicate the language and messages of the media releases and submissions.

The intended audiences for the documents in the data-set varied according to the document type, but included negotiators and governments (e.g. submissions), the general public (e.g. media releases) and the Industry and its shareholders (e.g. annual reports). The pharmaceutical industry uses a wide range of avenues to pursue its interests (Sell, 2007), and the sample represents a small subset of all possible texts.

Data analysis

Critical Discourse Analysis examines language for the ways it reflects and perpetuates power structures and dominant ideologies (Lupton, 1992; van Dijk, 1993). The pharmaceutical industry is well recognised to hold significant power in the context of trade negotiations (Sell, 2007), and this research explored how that power has been expressed through language in the context of negotiations for the TPPA. Since the Industry tended to frame the TPPA as solving a set of problems, we adopted a policy framework developed by Bacchi (1999) and previously applied in public health discourse analysis (Begley & Coveney, 2010) to explore what 'problem' PhRMA and MNZ purport that the TPPA will 'solve'. We assumed that PhRMA and MNZ documents reflect the policy the organisations would wish governments to adopt in the TPPA; hence, the documents can be viewed as de facto policy documents.

Bacchi's (1999, p. 1) basic question for policy analysis is, 'What is the problem represented to be?'. With this in mind, we applied the following questions to the data during analysis:

(1) What kinds of language and ideas are used to frame the TPPA?
(2) What drivers of the pharmaceutical industry agenda are evident in the language and ideas used?
(3) What evidence is there of the industry co-opting public health concepts?
(4) What remains unspoken/unwritten about the Industry, access to medicines and the TPPA in the data?

We adopted a 'thematic analysis' approach (Braun & Clarke, 2012) by devising codes for patterned ideas to extract a set of 'themes' evident from the data. Coding was initially carried out semi-independently by each researcher through a series of steps and then codes were discussed together in an iterative process to create themes. A deductive approach, consistent with a critical orientation (Braun & Clarke, 2012), and an inductive approach, in order to examine in-depth how PhRMA and MNZ constructed their arguments, were used.

Results

PhRMA and MNZ portrayed the TPPA trade provisions as fixing or addressing three 'problems':

(a) Unfair treatment of the patent-holding medicines industry by governments;
(b) the resultant restricted access to 'innovative medicines'; and
(c) the (US) economic crisis.

These 'problems' were framed in particular ways. The Industry was personified as the victim of unfair treatment, as the protector of the public good and as economic saviour. These were the major discourses in the data and relate to the portrayal of the TPPA as solving the 'problems' identified above.

The industry as victim

There was a strong *discourse of inequity* evident in all documents. The Industry was personified as researchers and innovators, who have received inequitable treatment by governments in comparison to the generic pharmaceutical industry. PhRMA referred to the patented pharmaceutical companies in the US as 'American innovators' (2012 media release) and spoke of the 'need to be doing more to champion researchers and innovators who rely on strong [intellectual property] protections' (2013 media release). These 'people' were then represented to be victims whose rights have not, to date, been adequately protected by 'foreign governments' (i.e. outside the USA). In a March 2009 submission to the Office of the USTR, PhRMA wrote:

> PhRMA believes that the TPP FTA negotiations […] could help ensure that US-based biopharmaceutical products have as fair and equitable access to foreign markets as foreign products have to ours.

In PhRMA texts, this framing of the Industry as a victim was most evident in submissions responding to a new country's expression of interest in joining the negotiations. For example, a 2010 submission on Mexico joining the TPPA expressed the view that local pharmaceutical manufacturers should not be receiving 'preferential treatment' (over transnational pharmaceutical companies). In 2013, PhRMA expressed concern about 'Canada's IP environment', particularly its 'uncertainty and instability for innovators', which was seen to 'harm US biopharmaceutical companies operating in Canada' (PhRMA 2013 submission to USTR).

This framing was also reflected in MNZ documents. The term 'level playing field' was used; a sporting metaphor commonly used in New Zealand to refer to equality of opportunity.

> Unifying those standards across the Asia Pacific region will provide the level playing field needed to bring the benefits of new products to patients. (MNZ media release, 2012)

It is notable that the concept of the level playing field is based on everyone playing by the same set of rules, and not on everyone having an equal chance of success (Wikipedia, 2014). In a 2008 submission about PHARMAC, the Researched Medicines Industry Association (MNZ's precursor) complained about the unfairness of medicines regulatory processes in New Zealand:

> PHARMAC's aggressive reference pricing models have acted to erode the intellectual property rights of innovative medicine suppliers. (RMI submission to Ministry of Foreign Affairs and Trade, 2008, p. 8).

By using the emotive term 'aggressive', MNZ cast the Industry in the role of victim and suggested a punitive, unfair motive for PHARMAC's price regulation.

Alongside the discourse of inequity sits the second problem: restricted access to new medicines in many nations. In the data, these two issues were framed as if they

were directly related. The national policies, which the Industry deems unfair to pharmaceutical companies, were argued to reduce access to new medicines. For example, a statement about the difficult 'market access environment' for pharmaceutical companies in Canada was followed by 'These issues hamper Canadian patient access to innovative medicines as well' (2012 PhRMA submission to USTR).

The industry as protector of public good

In the data, the Industry represented itself as contributing to the global public good through research and the development of new medicines. In positioning itself this way, PhRMA used emotive language to set up a 'crisis', which PhRMA, through the TPPA, would solve. For example, PhRMA referred to itself as '… offering new hope to those suffering from life-threatening disease or disability …' (2012 PhRMA submission on Mexico's expression of interest). The urgency of opportunity created for the Industry through the TPPA was framed as an imperative to act quickly in order to save lives.

PhRMA framed itself as a protector of the public good, both with regard to new medicines and the counterfeit drug market. PhRMA stated that it was '... contributing to the fight against dangerous counterfeit drugs' (2009 PhRMA submission to USTR). In the same document, the argument for stronger IP protections via the TPPA was framed in terms of protecting public health: 'Lax IP protections abroad spawn counterfeit copies of IP-protected products which severely jeopardise public health'. The implication is that governments do not go far enough to protect the public from counterfeit drugs, and that the TPPA would ensure such protection through increased IP rights for the patent-holding pharmaceutical industry. Further, PhRMA conflated generic medicines with the black market sale of unregulated medicines in this framing.

The following quote from PhRMA's 2009 submission to the USTR demonstrates the 'crisis creation':

> Failure to improve access to foreign markets means … fewer new life-saving medicines for all of us … Such policies will help ensure timely patient access to advanced life-saving medical discoveries, support improvement in quality of life and productivity.

These statements frame the Industry as altruistic and acting urgently for all people. The use of the first-person plural ('us') creates the illusion that PhRMA and all TPPA governments share a unified agenda.

This personification of the Industry as both victim and protector seems likely to have been directed to several audiences. Primarily, PhRMA had to convince the USTR to prosecute its case in the negotiations. Messages about life-saving drugs and benefits for patients may have also been geared to engender support from the powerful medical profession, from patient groups lobbying for access to high-cost new medicines and from members of the US Congress.

Economic saviour

The next theme relates to the third problem (c): the economic crisis. The language in the data-set framed the TPPA as enabling the Industry to be a saviour in the context of the global economic crisis, and the means to economic recovery for the USA, and (later) other economies as well. Increased IP protections and foreign market access for the pharmaceutical industry were presented as the solution to US economic problems:

> … the industry is vital to the American economy and to US employment … Failure to improve access to foreign markets means fewer jobs in the United States. (2009 PhRMA submission)

Framing the issue as one of national interest in this way obscures the Industry's vested interests.

It appears that in the earlier stages of the negotiations, PhRMA's claims about economic prosperity were directed primarily at US politicians. From 2012, however, there was evidence of a shift in this discourse, suggesting that the TPPA would lead to economic gain for all nations involved in the negotiations. The following excerpt from a PhRMA 2012 media release highlights this shift:

> … a strong, ambitious TPP which would further economic growth by strengthening American trade with the Asia-Pacific region … driving economic growth, jobs and competitiveness here at home and abroad … advancing their own [other nations'] economic growth, productivity, exports, innovation and the interests of their workers and consumers alike … This is critical to the future prosperity of the United States and its eight TPP negotiating partners.

The shift in discourse to encompass claims about economic prosperity for all countries may have been a response to the growing success during 2011–2012 of civil society organisations in drawing attention to the way in which increased IP protection threatens access to affordable medicines (Medecins Sans Frontieres, 2012). These civil society messages were taken up more widely in media reporting following leaks of negotiating documents in 2011 (Trans Pacific Partnership, 2011a, 2011b), which generated public outrage over the US demands. The shift also reflects a widening of PhRMA's audience: as developing countries' resistance to the US proposals grew, PhRMA increasingly needed to persuade other countries of the benefits of increased IP.

Unsubstantiated claims were made by PhRMA, implying that developed and developing countries would benefit equally from the TPPA, as in the following quote:

> … the adoption of strong IP protections by all countries in the TPP more widely promotes strong benefits for all … (2012 PhRMA submission to USTR)

The MNZ data at that time also reflected the language of economic prosperity:

> New Zealand has a wealth of creative and innovative expertise and these great ideas need to be protected for the benefit of the country's economy. (MNZ media release, 2012)

Since the pharmaceutical industry in New Zealand is largely comprised of subsidiary companies of transnational corporations, the talk of harnessing innovative ideas for New Zealand's economic benefit obscures the real beneficiaries of such arrangements.

In data from both organisations, claims about the TPPA leading to economic growth, jobs and prosperity in the TPPA countries were often made in the same sentences as claims about health outcomes. The TPPA was presented as a 'win-win' for national economies, population health outcomes and the patent-holding pharmaceutical industry:

> Such policies will help ensure timely patient access to advanced life-saving medical discoveries, support improvements in quality of life and productivity, and serve as an engine for future economic growth. (2009 PhRMA submission to USTR)

> The areas of improvement are aimed at achieving a win-win for patients and the medicines industry … (TPP – the NZ Medicine's Industry Perspective, undated pamphlet from Dec/12 negotiating round)

Discussion

This discussion addresses five questions based on Bacchi's (1999) framework for critical policy analysis:

- What is the problem represented to be?
- What are the effects produced by this representation?
- How are agents or actions constituted in the representation?
- Who is likely to benefit?
- What is left unproblematic?

The 'access to medicines' problem is represented by the Industry in the USA and NZ as a lack of fair access to so-called 'innovative' medicines. This situation is represented as unjust for all people, nations, the Industry and researchers. It is portrayed as having negative impacts on employment, research, economic development in the USA and, in later documents, in all TPPA nations. In some cases, the current situation was also seen as leading to the development of counterfeit drugs. Both US and NZ pharmaceutical industry statements have, thus, redefined the term 'access to medicines' to mean 'the availability of patented medicines', rather than 'access to affordable medicines'.

Representing 'access to medicines' this way redefines it as bringing new medications and technology to markets, obscuring the usual meaning of *equitable access to affordable medicines*. Access to medicines is generally defined by organisations such as WHO in terms of 'equitable availability and affordability of essential drugs'(World Health Organization, 2001). The Industry's reconstruction of the meaning of 'access to medicines' may be designed to garner support from clinicians, policy-makers and politicians. This construction may also appeal to patient groups concerned about access to new medicines, for example, for rare diseases.

Further, this representation obscures both the economic interests of the Industry and the messages of public health advocates who seek to ensure access to affordable drugs. The appeal to equity and fairness covers a multitude of awkward questions and issues, not least that the policies promoted by Industry are likely to decrease access to medicines, affecting population groups that are already disadvantaged (Gleeson et al., 2013; Monasterio & Gleeson, 2014). As Schrecker (2014) has argued, modern trade agreements have facilitated 'the inequality machine', such that governments can be forced to make choices between access to essential medicines and other ('economic') priorities.

The PhRMA and MNZ documents simultaneously present the Industry as 'victim', upon whom injustices have been occurring, and saviour, bringing medicines to the world. Nations with strong pharmaceutical regulation are represented as weak and inefficient; however, they are also represented as perpetrators, limiting the industry's 'missionary' efforts. The US is represented by PhRMA as ailing economically while, at the same time, being capable of saving other countries if strong intellectual property privileges are included in the TPPA. Further, the interests of TPPA countries' economies, patients and the Industry are conflated in the discourses.

Despite rhetoric about benefits for patients and nations, the Industry would benefit most from the policy positions it seeks to advance. The rhetorical panache of 'win-win outcomes' for the Industry, all TPPA governments and patients obscures the Industry's economic interests and the way in which it seeks to promote them at the expense of the public interest. For example, MNZ arguably intends to undermine the effectiveness of PHARMAC, as it has saved taxpayers millions of dollars in pharmaceutical expenditure by curtailing Industry profits.

What is absent from the Industry's discourses is revealing. The lack of affordable medicines in many countries is completely left out of the picture. As would be expected, the documents omit to mention that increasing IP protection leads to higher costs, and that this affects health equity. Further, there is an assumption built into the industry narrative that patented medicines are necessarily 'innovative'. Many new medicines, however, are actually only incremental changes to existing drugs, which offer little or no additional benefits over those existing drugs (Hollis, 2004; Régnier, 2013). Between 1993 and 2004 in the US, for example, pharmaceutical research and development expenditure increased by 147%, while marketing applications for 'new molecular entities' rose by only 7% (Government Accountability Office, 2006).

Conflating generic drugs with counterfeit drugs and positioning itself as fighting against life-threatening contaminated products through increased IP protection are well-worn Industry strategies. Researchers have shown, however, that strong IP protection actually provides opportunity and incentives to counterfeit drugs; it is part of the problem, rather than the solution (Outterson & Smith, 2006).

The highly contestable arguments that increasing IP protection improves access to medicines and leads to more investment in research and development are also left unproblematic. There is a large body of literature challenging the assumption that stronger IP protection leads to greater investment in new drugs development. For example, Palmedo (2013) compared pharmaceutical investment in 45 countries, including 36 countries that had a period of data exclusivity and nine that did not, and found that there was no relationship between whether or not a country had data exclusivity and the amount of investment in the country by the pharmaceutical industry. Kyle and McGahan (2009) found that following the adoption of the TRIPS Agreement, increased patent protection did not lead to more research into diseases most prevalent in developing countries. In fact, researchers have found that the pharmaceutical industry contributes a very small share of health research globally, with governments and the public contributing over 84% of the costs (Light, 2006).

There are logical fallacies inherent in Industry arguments that increasing IP protection creates jobs (Dourado & Robinson, 2014). For example, just because an industry is 'IP-intensive' does not mean that employment in that industry depends on IP. Patents can raise the price of goods, which reduces consumer spending and can lead to loss of jobs in the long term; increasing IP protection can actually decrease economic welfare overall (Dourado & Robinson, 2014).

The assumption that the interests of the Industry are aligned with the interests of nations, patients and the general public is deeply embedded in the discourses described in this paper. In fact, it is evident from the data that the patent-holding pharmaceutical industry in the USA and the US Government have shared interests; a finding that might explain why the Industry has had privileged access to inside knowledge about the TPPA negotiations. In terms of Critical Discourse Analysis, the Industry has had 'access to discourse' (van Dijk, 1993) in the TPPA negotiations, and therefore been able to exert powerful influence, at least in shaping the US position in the early stages.

Conclusions

Literature about the TPPA produced by the pharmaceutical industry is aimed at growing the power of the Industry. PhRMA and MNZ adopted public health notions of equity, rights and access to medicines in ways which serve their own economic aims. The Industry claims to be advocating for 'access to medicines' when it is actually lobbying for *access to markets*. The courses of action advocated by the Industry would increase current inequities in access to medicines within TPPA nations; however, their statements obscure this by co-opting public health language, reconstructing its meaning while omitting many key issues or leaving them unproblematic.

The extent to which the pharmaceutical industry rhetoric will influence the outcomes of the negotiations is unclear, given that, at the time of writing, they have not yet been concluded. It is also yet to be determined to what extent governments may be prepared to trade off access to medicines in exchange for market access in other sectors (Lopert & Gleeson, 2013). PhRMA's messages appear to be receiving support in the US, since recently leaked documents indicate the US is continuing to pursue many demands of PhRMA despite opposition from the other countries. MNZ appears to be having less success influencing the New Zealand Government's position; NZ was one of several countries that tabled a counter-proposal to the US proposal on intellectual property (TPP, 2013). The NZ Government does appear to be prepared to make some concessions to the USA; Medicine New Zealand's rhetoric may be a factor at play in shaping New Zealand's negotiating position.

Understanding the aims of the pharmaceutical industry and the way in which it uses language to shape debate and exert influence is important for public health advocates. This can help advocates to expose the way in which vested interests are being obscured; highlight issues that are left out by this framing; and develop arguments to counter the pharmaceutical industry's influence on international trade in the interests of public health. As previous commentary in this journal has highlighted, health inequity is a global public health issue to which regional trade agreements are contributing (Labonte & Torgerson, 2005; Schrecker, 2014). These are dynamics with which the public health community must engage.

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References

Bacchi, C. L. (1999). *Women, policy and politics*. London: Sage.

Begley, A., & Coveney, J. (2010). Wonder vitamin or mass medication? Media and academic representation of folate fortification as a policy problem in Australia and New Zealand. *Australian and New Zealand Journal of Public Health, 34*, 466–471.

Braun, V., & Clarke, V. (2012). Chapter 4: Thematic analysis. In H. Cooper (Ed.), *APA handbook of research methods in psychology: Volume 2. Research designs*. (pp. 57–71). Washington, DC: American Psychological Association.

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

Dourado, E., & Robinson, I. (2014). *How many jobs does intellectual property create?* Arlington, VA: Mercatus Center, George Mason University.

Faunce, T. A., & Townsend, R. (2010). Public health and medicine policies. In J. Kelsey (Ed.), *No ordinary deal: Unmasking the Trans-Pacific Partnership free trade agreement* (pp. 149–162). Crows Nest: Allen & Unwin.

Faunce, T. A., & Townsend, R. (2011). The Trans-Pacific Partnership Agreement: Challenges for Australian health and medical policies. *Medical Journal of Australia, 194*, 83–86.

Gleeson, D., Lopert, R., & Reid, P. (2013). How the Trans Pacific Partnership Agreement could undermine PHARMAC and threaten access to affordable medicines and health equity in New Zealand. *Health Policy, 112*, 227–233.

Government Accountability Office. (2006). *New drug development: Science, business, regulatory and intellectual property issues cited as hampering drug development efforts*. GAO-07-49. Retrieved December 31, 2013, from http://www.gao.gov/new.items/d0749.pdf

Hollis, A. (2004). *Me-too drugs: Is there a problem?* Retrieved January 24, 2014, from http://www.who.int/intellectualproperty/topics/ip/Me-tooDrugs_Hollis1.pdf

Jatrana, S., Crampton, P., & Norris, P. (2011). Ethnic differences in access to prescription medication because of cost in New Zealand. *Journal of Epidemiology & Community Health, 65*, 454–460.

Kemp, A., Glover, J., Preen, D. B., Bulsara, M., Semmens, J., & Roughead, E. E. (2013). From the city to the bush: Increases in patient co-payments for medicines have impacted on medicine use across Australia. *Australian Health Review, 37*, 4–10.

Kilic, B., & Maybarduk, P. (2012). *Comparative analysis of the United States' Intellectual Property Proposal and Laws of New Zealand*. Washington, DC: Public Citizen.

Kirk, A. R. (2012). *2012 Special 301 Report, USA*. Retrieved from http://www.ustr.gov/sites/default/files/2012%20Special%20301%20Report.pdf

Kyle, M. K., & McGahan, A. M. (2009). *Investments in pharmaceuticals before and after TRIPS*. NBER Working Paper No. 15468. Cambridge, MA: National Bureau of Economic Research.

Labonte, R., & Torgerson, R. (2005). Interrogating globalization, health and development: Towards a comprehensive framework for research, policy and political action. *Critical Public Health, 15*, 157–179.

Light, D. W. (2006). Basic research funds to discover important new drugs: Who contributes how much? In M. A. Burke & A. de Francisco (Eds.), *Monitoring financial flows for health research 2005: Behind the global numbers* (pp. 28–45). Geneva: Global Forum for Health Research.

Lopert, R., & Gleeson, D. (2013). The high price of "free" trade: US trade agreements and access to medicines. *Journal of Law, Medicine and Ethics, 41*, 199–223.

Lupton, D. (1992). Discourse analysis: A new methodology for understanding the ideologies of health and illness. *Australian Journal of Public Health, 16*, 145–150.

Medecins Sans Frontieres. (2012). Trading away health: How the US's intellectual property demands for the Trans-Pacific Partnership Agreement threaten access to medicines. *MSF Access Campaign Issue Brief*. Retrieved from http://www.msfaccess.org/sites/default/files/MSF_assets/Access/Docs/Access_Briefing_TPP_ENG_2012_update.pdf

Ministry of Health. (2013). *New Zealand Health Survey: Annual update of key findings 2012/13*. Wellington: Ministry of Health.

Moir, H., Tenni, B., Gleeson, D., & Lopert, R. (2014). *Assessing the impact of alternative patent systems on the cost of health care: The TPPA and HIV treatment in Vietnam*. Paper presented at the Asia-Pacific Innovation Conference, University of Technology, Sydney. Retrieved from http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2536254

Monasterio, E., & Gleeson, D. (2014). The Trans Pacific Partnership Agreement: Exacerbation of inequality for patients with serious mental illness. *Australian and New Zealand Journal of Psychiatry, 48*, 1077–1080.

Nguyen, A. T., Knight, R., Mant, A., Cao, Q. M., & Auton, M. (2009). Medicine prices, availability, and affordability in Vietnam. *Southern Med Review, 2*, 2–9.

Outterson, K., & Smith, R. (2006). Counterfeit drugs: The good, the bad and the ugly. *Albany Law Journal of Science and Technology, 16*, 525–543.

Oxfam America. (2011). *Oxfam America analysis of the USTR Trade Enhancing Access to Medicines (TEAM) white paper*. Retrieved from http://www.citizen.org/documents/Oxfam-America-Analysis-of-USTR-TEAM-White-Paper.pdf

Palmedo, M. (2013). Do pharmaceutical firms invest more heavily in countries with data exclusivity? *Currents International Trade Law Journal*.

PHARMAC. (2013a). Pharmaceutical Management Agency annual report for the year ended 30 June 2013. In *PHARMAC* (Ed.), Wellington: Pharmaceutical Management Agency. Retrieved March 2015, from https://www.pharmac.health.nz/assets/annual-report-2012-2013.pdf

PHARMAC. (2013b). *Purchasing medicines (Pamphlet)*. Retrieved 20 June, 2014, from http://www.pharmac.health.nz/assets/infosheet-05-purchasing-medicines-2013.pdf

Pharmaceutical Research and Manufacturers of America (2009). *PhRMA written comments concerning the proposed Trans-Pacific Partnership Free Trade Agreement with Singapore, Chile, New Zealand, Brunei Darussalam, Australia, Peru and Vietnam*. Retrieved March 2013, from www.regulations.gov

Program on Information Justice and Intellectual Property (n.d.). *IP enforcement database: The revolving door* [Webpage]. Retrieved August 17, 2013, from https://sites.google.com/site/iipenforcement/the-revolving-door

Ragupathy, R., Aaltonen, K., Tordoff, J., Norris, P., & Reith, D. (2012). A 3-dimensional view of access to licensed and subsidized medicines under single-payer systems in the US, the UK, Australia and New Zealand. *Pharmaco Economics, 30*, 1051–1065.

Régnier, S. (2013). What is the value of 'me-too' drugs? *Health Care Management Science, 16*, 300–313.

Researched Medicines Industry Association of New Zealand Incorporated. (2008). *Trans Pacific Strategic Economic Partnership Agreement: Submission to Ministry of Foreign Affairs and Trade from the Researched Medicines Industry Association of New Zealand Incorporated*. Retrieved March, 2013, from http://mfat.govt.nz/Trade-and-Economic-Relations/2-Trade-Relationships-and-Agreements/Trans-Pacific/index.php

Schrecker, T. (2014). Globalization, austerity and health equity politics: Taming the inequality machine, and why it matters. *Critical Public Health,* doi:10.1080/09581596.2014.973019

Searles, A., Doran, E., Faunce, T. A., & Henry, D. (2013). The affordability of prescription medicines in Australia: Are copayments and safety net thresholds too high? *Australian Health Review, 37*, 32–40.

Sell, S. K. (2007). TRIPS-plus free trade agreements and access to medicines. *Liverpool Law Review, 28*, 41–75.

Sell, S. K., Fattahi, P., & Palmedo, M. (2011). Chapter 2: Networked governance and the USTR. In J. Karaganis (Ed.), *Media piracy in emerging economies* (pp. 75–98). Brooklyn, NY: Social Science Research Council.

Smith, R. D., Correa, C. M., & Oh, C. (2009). Trade, TRIPS, and pharmaceuticals. *The Lancet, 373*, 684–691.

Trans Pacific Partnership. (2011a). *Intellectual property rights chapter (selected provisions)*. Retrieved September 2011, from http://www.citizenstrade.org/ctc/wp-content/uploads/2011/10/TransPacificIP1.pdf

Trans Pacific Partnership. (2011b). *Intellectual property rights chapter draft*. Retrieved February 10, 2011, from http://keionline.org/sites/default/files/tpp-10feb2011-us-text-ipr-chapter.pdf

Trans Pacific Partnership. (2011c). *Transparency chapter – Annex on Transparency and Procedural Fairness for Healthcare Technologies, June 22, 2011*. Retrieved 17 August 2013, from http://www.citizenstrade.org/ctc/wp-content/uploads/2011/10/TransPacificTransparency.pdf

Trans Pacific Partnership. (2013). Intellectual property [Rights] chapter – Consolidated text. [Leaked draft text]. *Wikileaks Release*, November 13, 2013. Retrieved 24 November 2013, from http://wikileaks.org/tpp/static/pdf/Wikileaks-secret-TPP-treaty-IP-chapter.pdf

Trans Pacific Partnership. (2014). *Intellectual property [Rights] chapter - Consolidated text. Ho Chi Minh Round - May 16, 2014* [Leaked draft text]. Retrieved March, 2015 from https://wikileaks.org/tpp-ip2/

UNAIDS. (2013). *UNAIDS report on the global AIDS epidemic 2013.* Retrieved from http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf

van Dijk, T. A. (1993). Principles of critical discourse analysis. *Discourse & Society, 4*, 249–283.

Wikipedia. (2014). *Level playing field*. Retrieved January 26, 2014, from http://en.wikipedia.org/wiki/Level_playing_field

World Health Organization. (2001). *How to develop and implement a national drug policy.* Retrieved from http://apps.who.int/medicinedocs/pdf/s2283e/s2283e.pdf