

Available online at www.sciencedirect.com

Public Health

journal homepage: www.elsevier.com/puhe

Governance for Health Special Issue Paper

Bringing (domestic) politics back in: global and local influences on health equity

Ted Schrecker*

School of Medicine, Pharmacy and Health, Queen's Campus, University Boulevard, Thornaby, Stockton-on-Tees TS17 6BH, United Kingdom

ARTICLE INFO

Article history:

Received 30 December 2014

Received in revised form

12 May 2015

Accepted 13 May 2015

Available online xxx

Keywords:

Social determinants of health

Health equity

Globalization

Climate change

Policy space

Trade

Poverty

Economic inequality

ABSTRACT

The *Lancet*-University of Oslo Commission on Global Governance for health correctly concluded that: 'with globalization, health inequity increasingly results from transnational activities that involve actors with different interests and degrees of power'. At the same time, taking up that Commission's focus on political determinants of health and 'power asymmetries' requires recognizing the interplay of globalization with domestic politics, and the limits of global influences as explanations for policies that affect health inequalities. I make this case using three examples – trade policy, climate change policy, and the domestic politics of poverty reduction and social policy – and a concluding observation about the 2015 UK election.

© 2015 The Royal Society for Public Health. Published by Elsevier Ltd. All rights reserved.

Introduction

The conference where the original version of this analysis was presented took place against the backdrop of the Ebola outbreak in Sub-Saharan Africa. The outbreak dramatized the weaknesses of the region's national health systems, and threatened to exacerbate those weaknesses as 'secondary health crises' emerge in such areas as malaria, nutrition and maternal care.¹ The weaknesses reflect international influences. Rowden has argued that 'the conspicuous

unpreparedness of countries like Guinea, Liberia, and Sierra Leone is a direct consequence of years of insufficient public investment in the underlying public health infrastructure' – and, further, that the International Monetary Fund (IMF)'s obsession with fiscal restraint is partly to blame.¹ Other authors have similarly pointed to the connections between the region's extreme poverty and its integration into the global economy on highly exploitative terms, through such processes as land grabbing by foreign actors.²

This example shows the importance of one of the conclusions reached by the *Lancet*-University of Oslo Commission on

* Tel.: +44 191 334 0398.

E-mail address: Theodore.schrecker@durham.ac.uk.

<http://dx.doi.org/10.1016/j.puhe.2015.05.007>

0033-3506/© 2015 The Royal Society for Public Health. Published by Elsevier Ltd. All rights reserved.

Global Governance for Health: ‘with globalization, health inequity increasingly results from transnational activities that involve actors with different interests and degrees of power’.³ (p. 630) The Commission also foregrounded the concepts of ‘power asymmetries’ and ‘political determinants of health’, which introduce a further level of complexity to the analysis. While the Commission was primarily concerned with power asymmetries on a global scale, in fact they operate on multiple scales, often involving the effects of globalization and global (or at least transnational) economic and political actors on domestic economic opportunity structures, resource distributions, and politics. Further, there are situations in which domestic political choices are crucial enablers, facilitators or promoters of globalization. In still other cases, globalization plays only a minor role in shaping political preferences and policy choices that affect health and health inequalities. An adequate understanding of the political determinants of health must include and recognize all these possibilities, paying special attention to interactions between the global and the domestic or the local. Here I present three examples – all that space constraints permit, but enough to demonstrate the importance of such interactions for understanding the politics of health and to suggest the value of a larger research program, as part of what has been called a ‘political science of health’.⁴

Example 1: trade policy

In a world where production is routinely organized across multiple national borders in complex commodity and value chains, trade policy is not only about tariffs and non-tariff limitations on trade, but also about investment and various ‘behind-the-border’ policies including standards related to public health. A key characteristic of the post-1995 World Trade Organization (WTO) regime, and an accompanying proliferation of bilateral and plurilateral agreements some of which actually predate the WTO, is that they restrict governments’ policy space: ‘the freedom, scope, and mechanisms that governments have to choose, design, and implement public policies to fulfil their aims’.⁵ (p. 105) Notably, harmonization of intellectual property protection under provisions of the Agreement on Trade-Related Aspects of Intellectual Property (TRIPs), which were driven by the economic interests of US pharmaceutical and information technology corporations,⁶ has restricted governments’ ability to provide access to essential medicines. This impact has been magnified by so-called TRIPS-plus provisions in bilateral and plurilateral agreements.³ (p. 642),⁷ More recently, intellectual property protection under trade agreements has been invoked by the tobacco industry as a basis for opposing plain packaging requirements.³ (p. 643–4)

Other health impacts are less conspicuous. For example, an expanding body of research indicates that trade and investment liberalization have facilitated the unhealthy transformation of diets in low- and middle-income countries (LMICs) by fast food chains, supermarkets, and producers of ultra-processed foods.^{8–10} Mexico, where such trends are especially conspicuous, now has obesity rates comparable to those in the United States. When countries lower trade

barriers and make labour markets more ‘flexible’ in order to attract foreign investment, the result is often destruction of livelihoods by imports that may be heavily subsidized.¹¹ The health consequences that result¹² are much more difficult to document to an epidemiological standard of proof, at least until long after the window of opportunity for policies to protect employment and health has closed.

In some cases, trade and investment liberalization has been a response to IMF and World Bank conditionalities, a key aim of which was to restructure national economies around competitive export sectors in order to protect countries’ ability to repay foreign debts. Even when such conditionalities are not an issue, large economies (like the United States) or economic blocs (like the European Union) have a formidable bargaining advantage in bilateral or plurilateral negotiations with smaller economies, meaning they are able to demand major concessions (in areas like intellectual property protection, which can drive up the costs of medicines) in exchange for limited increases in access to their markets.¹³ The negotiation of trade and investment agreements thus exemplifies global power asymmetries. However, such asymmetries exist within countries as well as among them. When governments enter into trade and investment agreements or make other kinds of commitments involving the global marketplace, they may be accepting risks on behalf of vulnerable groups with limited political voice, in the interests of securing gains to domestic constituencies such as export industries or property investors. This helps to explain why governments accept provisions that may expand market access for attract foreign investment even as they limit access to essential medicines by raising their cost, or create new constraints on policy space through investor-state dispute settlement (ISDS) mechanisms that are beyond effective democratic control.^{14,15}

In such cases, the role of external influences on trade policy is limited; they may function primarily as a way of adding credibility to domestic elite agendas. Policy elites led Mexico unilaterally to liberalize trade and expose domestic producers to foreign competition well before it agreed to do so within the North American market under the North American Free Trade Agreement (NAFTA);¹⁶ it has been argued that NAFTA itself was adopted in order to lock in neoliberal domestic economic policies by restricting future governments’ policy space,¹⁷ for example through its ISDS provisions. Thus, although global inequalities clearly play a role in explaining the health consequences of the contemporary trade policy regime, at least some trade policy commitments confirm Halperin’s view that: ‘globalization is a matter of deliberate organization and collective effort on the part of elites concerned to maintain a specific distribution of resources that subordinates labour and preserves elite privileges. The discourse of globalization emphasizes the necessity of governments to adapt to newness and difference, a necessity that forecloses choice. But government policies are designed, not to adapt to new circumstances, but to promote them’.¹⁸ (p. 224)

Example 2: climate change

Climate change was identified by a 2009 *Lancet* Commission as ‘the biggest global health threat of the 21st century’.¹⁹ The

week before the argument made in this article was first presented, the Intergovernmental Panel on Climate Change (IPCC) released its latest synthesis report, with such findings as: ‘in urban areas, climate change is projected to increase risks for people, assets, economies and ecosystems, including risks from heat stress, storms and extreme precipitation, inland and coastal flooding, landslides, air pollution, drought, water scarcity, sea-level rise, and storm surges (*very high confidence*). These risks are amplified for those lacking essential infrastructure and services or living in exposed areas’.²⁰ (p. SPM-11) Two direct parallels with the financial crisis that swept across the world in 2008 and led to the Great Recession are worth noting. First, well before the financial crisis, financial stability was recognized as a true global public good²¹ (one of a few). Climate stability likewise represents a true global public good, and like public goods in general it will be (and is) radically undersupplied by markets. Appropriate institutions for collective response are needed to ensure adequate provision of public goods and in this case, as with financial stability, they must operate at the supranational level. Second, as with the financial crisis, the adverse impacts of climate change on livelihoods and health will be felt first, and worst, by those who made almost no contribution to the crisis (in the form of greenhouse gas emissions) and have no control over its progression. This is yet another illustration of the consequences of power asymmetries on a global scale.

Held and colleagues have pointed out one set of obstacles to progress: the size and wealth of the affected industries.²² (p. 265) Stabilizing the world’s climate will require confronting an oil and gas industry that includes six of the top 10 companies on the *Financial Times* Global 500 list for 2014 (eight of the top 13) by revenue, three of the top 10 by profitability, and three of the top 12 by market capitalization.²³ Oil and gas is not the

only industry whose growth and profits will be affected by serious initiatives to stabilize global warming, and the oil and gas industry’s fortunes have important consequences for national and sub-national governments, like Canada’s and those of three of its provinces, with revenue streams that rely heavily on fossil fuel royalties and corporate incomes.

Another set of obstacles, rooted in domestic politics and policy preferences, is also relevant. Immediately outside the building where I work, as in much of the high-income world outside major urban centres, is a car park (Fig. 1). Twenty minutes’ walk away is a local landmark shopping park, which advertises more than 2000 free parking spaces. The convenience and comfort of driving are taken for granted as a reasonable expectation if not an entitlement. If Margaret Thatcher did not actually say that ‘a man who, beyond the age of 26, finds himself on a bus can count himself as a failure’, everyday conversations suggest that many people hold this belief. One can argue that proliferations of car parks are partly a response to under-investment in public transport, which is true, but the observation only underscores the importance of choices about policy priorities. Figures from the Royal Automobile Club Foundation show that between 2004 and 2014, the cost of travelling by coach or rail rose twice as fast as the cost of driving;²⁴ late in 2014 the UK government, with support from across the partisan spectrum, announced a £15 billion program of road construction.^{25,26} Apart from the car park and road building cultures, most OECD countries subsidize company cars, albeit to widely different degrees, with Germany – widely viewed as a leader in integrating environmental concerns into public policy – underwriting the average company car to the tune of almost 2500 Euros per year. Italy, in the midst of financial crisis, still spends almost as much.²⁷ Spending like the UK’s on roads and Italy’s on company cars



Fig. 1 – Ebsworth car park, Durham University, Stockton-on-Tees, United Kingdom.

underscores the highly selective nature of austerity; it seldom touches the prerogatives of the privileged.

Outside the high-income world, it is reasonable to assume that a few hundred million members of the expanding middle class would like to be able to treat automobiles as an entitlement in the same way that we do – even though they may not, as Friedman famously commented in an exchange with Ramonet, want to drive them to Disney World.²⁸ If the high-income world cannot kick the car park and company car habit, with its inequitable consequences,²⁹ it seems unreasonable to ask that people in considerably poorer parts of the world get out of the car and onto the train, or the cycle, or the pavement. Meanwhile, many such jurisdictions are already making policy choices that favour drivers who are for the moment in a minority.^{30–33} This reflects the same kind of power asymmetry within their boundaries that sustains subsidies for company cars in the high-income world, and shrinks the constituency for alternative strategies while literally casting future land use and settlement patterns in concrete.

Example 3: new economic cartographies

The importance of the politics of distribution and poverty reduction within national borders is suggested by the fact that roughly 70% of the world's poorest people – defined by the World Bank threshold of living on US \$1.25 or less per day – no longer live in the world's poorest countries.³⁴ Several large countries – Pakistan, India, Nigeria, and Indonesia – have moved out of the low-income grouping, again as defined by the World Bank, but substantial portions of their populations remain in extreme poverty.³⁴ This change has led Sumner to argue that: '[I]n the not-too-distant future, most of the world's poor will live in countries that do have the domestic financial scope to end at least extreme poverty ... This will likely pave the way for addressing poverty reduction as primarily a domestic issue rather than primarily an aid and international issue; and thus a (re)framing of poverty as a matter of national distribution and national social contracts and political settlements between elites, middle classes and the poor'.³⁴ (p. 3)

At least two problems with this formulation can be identified.

First, although Sumner may be correct about the declining relevance of aid for many countries, poverty reduction must remain an international issue with respect to such matters as controlling capital flight and corporate tax evasion. For example, capital flight has been a major impediment to African development, and thereby to the availability of resources of health care and poverty reduction, as African elites have shifted their assets into regions where risks are lower and returns higher.³⁵ Ndi-kumana and colleagues³⁶ estimate the value of capital flight from 39 African countries between 1970 and 2010 as US \$1.3 trillion (at 2010 currency values), or \$1.68 trillion if modest interest earnings are imputed. This is more than five times the value of the external debts of the countries in question, and more than the combined value of development assistance and foreign direct investment over the same period. Like the tango, capital flight requires two willing participants, and capital flight of this magnitude could not exist without welcomes from private banks and tax havens in rich countries.³⁷

Second, it is unwise to presume that the settlements Sumner anticipates will necessarily be favourable for reducing poverty or health inequity. Replication of something like the postwar political settlement between labour and capital in the high-income countries, in which governments of various political stripes agreed on collective bargaining rights, nearly full employment as a policy objective, and a more-than-minimal welfare state, cannot be relied upon. That settlement is under heightened threat from a combination of accumulated sovereign debt and recession.³⁸ Although reports of the settlement's death are premature, it looks increasingly like an historical anomaly, and governments have largely repudiated it in countries like the United States and the United Kingdom that have travelled farthest down the neoliberal road.

Outside the high-income world it is useful to consider Brazil, where successive Workers' Party governments have made major advances in reducing economic inequality³⁹ (from extremely high levels, and with the advantage of robust economic growth due to high commodity prices until circa 2012), expanding access to primary health care,⁴⁰ and reducing poverty through the *Bolsa Família* cash transfer program. At the same time, public investments 'brought large numbers of new government contracts to a familiar assortment of Brazil's large private companies', involving resources that 'dwarfed those spent on the *Bolsa Família*',⁴¹ and forced resettlements of the poor were carried out in order to acquire valuable sites for the Pan American Games and the Olympics – key elements in branding Brazil as a 'world class' destination for investment and tourism.⁴²

The Brazilian case may be broadly reflective of the power asymmetries and class compromises that can be expected at the benign end of the policy spectrum; even in contexts where social protections are expanded, far more resources may be mobilized for programs that serve the interests and priorities of the wealthy and powerful. And for every Brazil there is likely to be a Nigeria, where oil wealth is massively concentrated against a background of widespread extreme poverty,⁴³ or an India, where 182,000 millionaires and a top economic decile whose share of the country's product is rising⁴⁴ coexist with more than 400 million people living below the World Bank extreme poverty threshold, and 50% of the population had no alternative to outdoor defecation circa 2011.⁴⁵ In February 2015, a newly elected Indian government announced a 16% cut in its health budget,⁴⁶ despite national performance on basic indicators like immunization and child nutrition that lags well behind even poorer countries.⁴⁵

Discussion

In a world where production can easily be offshored and the global financial marketplace multiplies portfolio choices, distributional conflicts are no longer contained within national borders as they were during the era that gave rise to the postwar settlement. Globalization has magnified inequalities in resources among actors (like transnational corporations and trade unions) and classes within those borders. At the same time, too much can be made of the constraints associated with globalization – as evidenced, for example, by the three-fold variation in the prevalence of poverty after taxes and transfers in the high-income world.⁴⁷ High-income countries may be less

constrained than others by a range of global power asymmetries, as Mosley⁴⁸ has shown to be the case for financial markets. Nevertheless, it is difficult to see how globalization can explain policy choices like India's, or like the failure over a decade of most African Union countries to live up to their 2001 commitment (in the Abuja declaration) to increasing public spending on health to 15% of their general government budgets.⁴⁹ Much of the increase in inequality of market incomes in countries across the income spectrum may be attributable to globalization, but if globalization can explain (re)distributive policy choices it is at least partly by way of how global institutions and flows influence political allegiances and resources as they alter economic opportunity structures within a country's borders and change the resources available to domestic actors.

The importance of this distinction is more than academic. Before the financial crisis, health inequalities between rich and poor districts in Britain were larger on some measures than at any point since the Great Depression.⁵⁰ The UK election of 2015 saw the return to power with a Parliamentary majority of a Conservative government that had responded to the exigencies of the crisis with a (selective) austerity program that was on track to shrink public expenditure as a proportion of GDP to levels not seen since before the second World War,⁵¹ while overall redistributing income upward.⁵² The election outcome arguably substantiates Mackenbach's assertion that 'reducing health inequalities is currently beyond our means' in England, because the electorate would probably not support the 'massive re-allocation of societal resources' that would be necessary to counteract market influences that increase inequality.⁵³ (p. 1252) That lack of support, however, demands explanation rather than providing it, and global influences can plausibly supply only part of the explanation. The political science of health must consider the interplay between globalization and domestic politics, keeping in mind Halperin's observations about elite motivations and strategies, and develop more sophisticated analyses of the political conditions and coalitions that may make it possible to reduce health inequalities in a challenging environment.

Author statements

Ethical approval

None sought.

Funding

None.

Competing interests

None declared.

REFERENCES

- Rowden R. West Africa's financial immune deficiency. Foreign policy [On-line]. Available from: http://www.foreignpolicy.com/articles/2014/10/30/west_africas_financial_immune_deficiency Ebola_imf; 30 October 2014.
- People's Health Movement. Ebola epidemic exposes the pathology of the global economic and political system, PHM position paper. People's health movement [On-line]. Available from: http://www.phmovement.org/sites/www.phmovement.org/files/phm Ebola_23_09_2014final_0.pdf; 2014.
- Ottersen OP, Dasgupta J, Blouin C, Buss P, Chongsuvivatwong V, Frenk J, et al. The political origins of health inequity: prospects for change. *Lancet* 2014;**383**:630–67.
- Bambra C, Fox D, Scott-Samuel A. Towards a politics of health. *Health Promot Int* 2005;**20**:187–93.
- Koivusalo M, Schrecker T, Labonté R. Globalization and policy space for health and social determinants of health. In: Labonté R, Schrecker T, Packer C, Runnels V, editors. *Globalization and health: pathways, evidence and policy*. New York: Routledge; 2009. p. 105–30.
- Sell SK. Private power, public law: the globalization of intellectual property rights. Cambridge: Cambridge University Press; 2003.
- Correa CM. Public health and the implementation of the TRIPS agreement in Latin America. In: Blouin C, Drager N, Heymann J, editors. *Trade and health: seeking common ground*. Montréal: McGill-Queen's University Press; 2008. p. 11–40.
- Thow AM. Trade liberalization and the nutrition transition: mapping the pathways for public health nutritionists. *Public Health Nutr* 2010;**12**:2150–8.
- Hawkes C, Chopra M, Friel S. Globalization, trade, and the nutrition transition. In: Labonté R, Schrecker T, Packer C, Runnels V, editors. *Globalization and health: pathways, evidence and policy*. New York: Routledge; 2009. p. 235–62.
- Clark SE, Hawkes C, Murphy SME, Hansen-Kuhn KA, Wallinga D. Exporting obesity: US farm and trade policy and the transformation of the Mexican consumer food environment. *Int J Occup Environ Health* 2012;**18**:53–64.
- Schrecker T. Labor markets, equity, and social determinants of health. In: Labonté R, Schrecker T, Packer C, Runnels V, editors. *Globalization and health: pathways, evidence and policy*. New York: Routledge; 2009. p. 81–104.
- Benach J, Vives A, Amable M, Vanroelen C, Tarafa G, Muntaner C. Precarious employment: understanding an emerging social determinant of health. *Annu Rev Public Health* 2014;**35**:229–53.
- Stiglitz J, Charlton A. Common values for the development round. *World Trade Rev* 2004;**3**:495–506.
- Investor-state dispute settlement: the arbitration game. The Economist. Available: <http://www.economist.com/news/finance-and-economics/21623756-governments-are-souring-treaties-protect-foreign-investors-arbitration>; 11 October 2014.
- Reynolds L, McKee M. Is the NHS really safe from international trade agreements? *BMJ* 2015;**350**. <http://dx.doi.org/10.1136/bmj.h2179>.
- Cronin P. Explaining Free Trade: Mexico, 1985–1988. *Latin American Politics and Society* 2003;**45**:63–95.
- Grinspun R, Kreklewich R. Consolidating neoliberal reforms: "Free trade" as a conditioning framework. *Stud Political Econ* 1994;**43**:33–61.
- Halperin S. *Re-envisioning global development: a horizontal perspective*. London: Routledge; 2013.
- Costello A, Abbas M, Allen A, Ball S, Bell S, Bellamy R, et al. Managing the health effects of climate change: Lancet and University College London Institute for global health commission. *Lancet* 2009;**373**:1693–733.
- Intergovernmental Panel on Climate Change. *Climate change 2014 synthesis report – approved summary for policymakers*. Geneva: IPCC Secretariat. Available from: http://www.ipcc.ch/pdf/assessment-report/ar5/syr/SYR_AR5_SPM.pdf; 2014.

1. Rowden R. West Africa's financial immune deficiency. Foreign policy [On-line]. Available from: http://www.foreignpolicy.com/articles/2014/10/30/west_africas_financial_immune_deficiency Ebola_imf; 30 October 2014.

21. Griffith-Jones S. International financial stability and market efficiency as a global public good. In: Kaul I, Conceição P, LeGoulven K, Mendoza RU, editors. *Providing global public goods: managing globalization*. New York: Oxford University Press for the United Nations Development Programme; 2003. p. 435–54.
22. Hale T, Held D, Young K. *Gridlock: why global cooperation is failing when we need it most*. Cambridge: Polity Press; 2013.
23. Financial Times. Global 500 2014. Financial times [On-line]. Available from: <http://im.ft-static.com/content/images/7097ad1a-fded-11e3-bd0e-00144feab7de.xls>.
24. RAC Foundation. Transport price index: cost of travel over the last 10 years. RAC foundation [On-line]. Available from: <http://www.racfoundation.org/data/cost-of-transport-index>; November 2014.
25. Bienkov A. George Osborne's £15 billion road to nowhere. Politics.co.uk [On-line]. Available from: <http://www.politics.co.uk/blogs/2014/12/01/george-osborne-s-15-billion-road-to-nowhere>; 1 December 2014.
26. Press Association. Cameron to announce £15bn plan to improve UK's 100 road blackspots. The Guardian. Available from: <http://www.theguardian.com/uk-news/2014/nov/10/david-cameron-announce-15bn-boost-improve-100-road-blackspots>; 10 November 2014.
27. Organisation for Economic Co-operation and Development. Under-taxing drivers is bad for environment and health, OECD says. Paris: OECD. Available from: <http://www.oecd.org/newsroom/under-taxing-drivers-is-bad-for-environment-and-health.htm>; September 2014.
28. Friedman TL, Ramonet I. *Dueling globalizations: a debate between Thomas L. Friedman and Ignacio Ramonet*. Foreign Policy; Fall 1999:110–27.
29. Kay D. Fairness in a car-dependent Society. London: Sustainable Development Commission. Available from: http://www.sd-commission.org.uk/data/files/publications/fairness_car_dependant.pdf; 2011.
30. Alcantara de Vasconcellos E. Urban change, mobility and transport in São Paulo: three decades, three cities. *Transp Policy* 2005;12:91–104.
31. Rodgers D. Nueva Managua: the disembedded city. In: Davis M, Monk B, editors. *Evil paradises: dreamworlds of neoliberalism*. New York: New Press; 2007. p. 127–39.
32. Pucher J, Korattyswaropam N, Mittal N, Ittyerah N. Urban transport crisis in India. *Transp Policy* 2005;12:185–98.
33. Leaf M. Building the road for the BMW: culture, vision, and the extended metropolitan region of Jakarta. *Environ Plan A* 1996;28:1617–35.
34. Sumner A. From deprivation to distribution: is global poverty becoming a matter of national inequality? Working paper 394. Brighton: Institute of Development Studies. Available from: <http://www.ids.ac.uk/download.cfm?objectid=4BAE6EB0-B3B9-11E1-AE0B005056AA4739>; 2012.
35. Collier P, Hoeffler A, Pattillo C. Flight capital as a portfolio choice. *World Bank Econ Rev* 2001;15:55–80.
36. Ndikumana L, Boyce JK, Ndiaye AS. *Capital flight: measurement and drivers*, working paper 363. Amherst, MA: Political Economy Research Institute, University of Massachusetts. Available from: http://www.peri.umass.edu/fileadmin/pdf/working_papers/working_papers_351-400/WP363.pdf; 2014.
37. Collier P. A chance to crack down on Africa's loot-seeking elites. The Guardian. Available from: <http://www.guardian.co.uk/commentisfree/2008/oct/07/banking.regulation.africa>; 7 October 2008.
38. Schäfer A, Streeck W, editors. *Politics in the age of austerity*. Cambridge: Polity Press; 2013.
39. Barrientos A. The rise of social assistance in Brazil. *Dev Change* 2013;44:887–910.
40. Macinko J, Dourado I, Aquino R, PdF Bonolo, Lima-Costa MF, Medina MG, et al. Major expansion of primary care in Brazil linked to decline in unnecessary hospitalization. *Health Aff* 2010;29:2149–60.
41. Hochstetler K. Reducing poverty in Brazil: finding policy space for meeting development needs. In: Drache D, Jacobs LA, editors. *Linking global trade and human rights: new policy space in hard economic times*. Cambridge: Cambridge University Press; 2014. p. 197–215.
42. Sánchez F, Broudehoux AM. Mega-events and urban regeneration in Rio de Janeiro: planning in a state of emergency. *Int J Urban Sustain Dev* 2013;5:132–53.
43. Wallis W. Nigeria's super elite laps up luxury as 60% live in severe poverty. Financial Times [On-line]. Available from: <http://www.ft.com/cms/s/0/54a6d688-bb14-11e3-948c-00144feabdc0.html#axzz3L1QwcUwU>; 4 May 2014.
44. Stierli M, Shorrocks A, Davies JB, Lluberas R, Koutsoukis A. *Global wealth report 2014*. Zurich: Credit Suisse. Available from: <https://publications.credit-suisse.com/tasks/render/file/?fileID=60931FDE-A2D2-F568-B041B58C5EA591A4>; 2014.
45. Drèze J, Sen A. *An Uncertain glory: India and its contradictions*. London: Allen Lane; 2013.
46. Mudur G. Experts question how India will meet promises on public health after cut in budget for 2015–16. *BMJ* 2015;350. <http://dx.doi.org/10.1136/bmj.h1244>.
47. Schrecker T. Globalization, austerity and health equity politics: taming the inequality machine, and why it matters. *Crit Public Health*; 2014;. <http://dx.doi.org/10.1080/09581596.2014.973019>.
48. Mosley L. *Global Capital and National Governments*. Cambridge: Cambridge University Press; 2003.
49. Committee of experts of the 4th joint annual meetings of the AU conference of ministers of economy and finance and ECA conference of African ministers of finance planning and economic development. *Investment in health is an investment in economic development*. E/ ECA/COE/30/5/Rev.1. Addis Ababa: United Nations Economic Commission for Africa. Available from: <http://www.uneca.org/cfm/2011/documents/English/Investment-inHealth.pdf>; 2011 Feb 24.
50. Thomas B, Dorling D, Smith GD. Inequalities in premature mortality in Britain: observational study from 1921 to 2007. *BMJ* 2010;341. <http://dx.doi.org/10.1136/bmj.c3639c>.
51. Office for Budget Responsibility. *Economic and fiscal outlook*. London: HMSO. Available from: http://budgetresponsibility.org.uk/pubs/December_2014_EFO-web513.pdf; December 2014.
52. De Agostini P, Hills J, Sutherland H. *Were we really all in it together? The distributional effects of the UK coalition government's tax-benefit policy changes, social policy in a cold climate working paper 10*. London: Centre for Analysis of Social Exclusion, London School of Economics and Political Science. Available from: <http://sticerd.lse.ac.uk/dps/case/spcc/wp10.pdf>; 2014.
53. Mackenbach JP. Has the English strategy to reduce health inequalities failed? *Soc Sci Med* 2010;71:1249–53.