

Neoliberalism and health: The linkages and the dangers

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Abstract

A recent book addresses the health effects of **neoliberalism** using the provocative rubric of 'neoliberal epidemics'. This article reviews literature on the **health** effects of **neoliberalism** starting with the **structural adjustment** conditionalities mandated by the World Bank and the International Monetary Fund. It continues with an analysis of how **neoliberalism** increases economic **insecurity** and **inequality**, and the effects on **health**, with a section specific to the **health** impacts of **austerity** measures undertaken after the financial crisis that began in 2007. The next section considers contemporary **trade policy** as an embodiment of neoliberal ideology, and reviews current and anticipated **health** effects. The article concludes with a brief examination of two paradoxes that are evident in the research literature on **neoliberalism** and **health**.

Introduction

With specific reference to the United States (US) and the United Kingdom (UK), the large, high-income countries that have travelled farthest down the road of neoliberal economic and social policy, Clare Bambra and I (2015) argue that the health effects are best understood as a set of interacting 'neoliberal epidemics'. We actually combined three distinct categories: a health outcome (obesity); key social determinants of health outcomes (inequality and insecurity); and one of the policy drivers of those social determinants (austerity). This conflation arguably was justified because (a) an abundant evidence base connects inequality, insecurity and austerity with adverse health outcomes, of which obesity is only one; (b) the phenomena in question exist on such a scale and have spread so quickly across time and space that if they involved pathogens they would be seen as of epidemic proportions; and (c) the epidemics in question are direct consequences of neoliberal economic and social policies.

Definitional controversies pervade the academic world, so it is useful to consider the meaning of neoliberalism, especially since a recent journal editorial called for greater clarity, nuance and specificity in accounts of how neoliberalism influences public health (Bell and Green 2016). Bambra and I cited three core definitional elements. First, markets are regarded as the normal, natural, and preferable way of organizing most forms of human interaction, not just economic transactions in the conventional sense. Second, the primary function of the state is to ensure the efficient functioning of markets, although this does not necessarily mean a 'rolling back' of state functions. Indeed, the state may need to expand its activities in areas such as policing and interrogation of applicants for state support to which they are legally entitled – hence, Peck and Tickell's (2002) crucial distinction between 'roll out' and 'roll back' neoliberalism. Third, those who advocate a variety of redistributive policies must justify their positions against a 'baseline' (Sunstein 1987) outcome that would be generated by a market functioning as markets are supposed to in microeconomics textbooks.

A striking example of this third element is provided by the World Bank's advocacy of replacing social protection with 'social risk management' (Holzmann and Jörgensen 2001) based on the proposition that: 'In an ideal world with perfectly symmetrical information and complete, well-functioning markets, all risk management arrangements can and should be market-based (except for the incapacitated)' (p. 16). Thus, if governmental intervention to help the non-incapacitated poor is justified, it is only because of market failures resulting from the fact that the poor 'are more vulnerable than other population groups because they are typically more exposed to risk and have little access to appropriate risk management instruments' (p. 10). Ward and England (2007), who prefer to speak of 'neoliberalisation' as a process, provide a more detailed and nuanced definition, which characterises neoliberalism as simultaneously an ideology, a set of policies and programmes, a set of distinctive institutional forms, and a complex of normative conceptions of agency and responsibility that are rooted in the ideology and embodied in the policies, programmes and institutional forms. As we will see, the World Bank and its sister organisation, the International Monetary Fund (IMF), have functioned as promoters of all these dimensions of the neoliberal agenda.

Multiple pathways connect neoliberalism with health outcomes. One conventional typology in the health research literature divides these into material (e.g., effects on income adequacy or insecurity) and psychosocial (see e.g. the exchange between Lynch, Smith, Kaplan, and House 2000 and Marmot and Wilkinson 2001). On the material side it is surely relevant that, for example, official surveys show that 6.9 million US households experienced 'very low food security' in 2014, including 12.8 percent of all households with children headed by a single mother (Coleman-Jensen, Rabbitt, Gregory, and Singh 2015). However, this dichotomy is an oversimplification and a misdirection. Psychosocial dynamics have physiological consequences, for example in the case of chronic exposure to the stress associated with economic insecurity or subordinate position in a social hierarchy (Marmot and Sapolsky 2014; Wisman and Capehart 2012). Further, given neoliberalism's tendency

to exacerbate inequalities and insecurities, it is especially important to be sensitive to the multiple dimensions by which the social environment influences health: the social determinants of health (Commission on Social Determinants of Health 2008). People in different social positions inhabit very different 'epidemiological worlds' (Phillips 1994; Rydin et al. 2012) in which many things go on at once. They go on in ways that vary with the social position of the individual, the household and the community, and result in the accumulation of effects of (dis)advantage over the life course.

Failure to recognise such complexity is a key limitation of most epidemiological study designs, perhaps because of the legacy of an era of 'infectious diseases which could only be caused by exposure to a specific pathogen' (Pickett and Wilkinson 2015, 321); however the importance of recognizing complexity and multicausality is now acknowledged in the more methodologically sophisticated overviews of the social determinants of health (see notably Kelly and Doohan 2012; Whitehead et al. 2016). Multidimensional understandings of how neoliberalism and its manifestations affect health and the possibilities for leading a healthy life inform the present article. Without formal exclusion or inclusion criteria, it surveys the vast literature on the connections between neoliberalism and health, with reference to a larger range of countries than those considered by myself and Bambra and to international as well as domestic policies and actors, whilst emphasising early warnings provided by the experiences of jurisdictions that have travelled farthest down the neoliberal road. Thus, in the high-income world the US and UK remain in the foreground.

Structural adjustment and beyond

The term 'structural adjustment' (Milward 2000; Zack-Williams, Brown, and Mohan 2000) entered the development policy lexicon at the end of the 1970s, in the context of external debt crises that confronted many low- and middle-income countries (LMICs) as a consequence of aggressive lending of 'recycled' oil revenues by major banks; the effects of worldwide recession; and a sharp rise in interest rates triggered by the US Federal Reserve in 1979 (the 'Volcker shock'). There can be little

doubt that improvident borrowing by LMIC governments, in some cases to finance capital flight, contributed to the crisis. A temporary default by Mexico in 1982 placed the issue of LMIC on the agenda of the major high-income countries by threatening the stability of some major banks, and consequently the world's financial system. The term refers in the first instance to the Structural Adjustment Facility, the pool of funds from which the IMF, working in parallel with the World Bank, lent to LMICs in order to enable them to reschedule their payments to external creditors. The term was actually abandoned by the IMF in 1999, when its Enhanced Structural Adjustment Facility was rechristened the Poverty Reduction and Growth Facility as part of an increased emphasis on poverty reduction, at least at the level of rhetoric. (As we will see, the reality was somewhat different.) The term is often used to describe not just the specific responses to IMF and World Bank policy prescriptions but also, as by Babb (2005), the more general adoption of neoliberal economic and social policies with the aim of economic restructuring.

The importance of structural adjustment for health and health systems arises in the first instance from the impact of a relatively standard package of conditionalities demanded by the World Bank and IMF. These involved the reduction of domestic subsidies, privatisation of state-owned assets, deregulation of domestic markets (especially labour markets), and increased openness to imports and foreign direct investment in the interests of restructuring economies in order to improve their export competitiveness. In many cases, it is clear that the primary objective was protection of creditor interests, but a larger policy agenda was succinctly described in 1995 by a panel of social scientists: 'An alliance of the international financial institutions, the private banks, and the Thatcher-Reagan-Kohl governments was willing to use its political and ideological power to back its ideological predilections' (Przeworski et al. 1995, 5). Structural adjustment conditionalities were eventually applied to more than 75 LMICs, for varying periods of time; with varying degrees of compliance with their requirements; and – importantly – in parallel with the World Bank's increasingly forceful promotion of market-based health systems organised around private insurance and user charges to

provide revenue and shift decision-making power to health consumers, with public provision of health care relegated to a residual role (Keshavjee 2014, 93-96). In the words of the Bank's 1993 World Development Report on *Investing in Health*, an especially clear articulation of this perspective, '[t]here must be a basis for believing that the government can achieve a better outcome than private markets can' and the cost-effectiveness of publicly financed health interventions' must be determined by comparison 'with the situation created by privately financed health interventions' (World Bank 1993, 55, 65; see generally chapter 3).

- Insert Figure 1 about here -

As early as 1984, a cartoon in the *Los Angeles Times* (Figure 1) demonstrated an understanding of the social impacts of structural adjustment. In 1987, a UNICEF study of ten countries operating under structural adjustment conditionalities documented the adverse effects on child health and well-being in many of the study countries (Cornia, Jolly, & Stewart, eds. 1987), with its argument for 'adjustment with a human face' seeming to have little effect. By 2001, a review commissioned by the World Health Organization's Commission on Macroeconomics and Health (Breman and Shelton 2001; shortened version published as Breman and Shelton 2007) identified 76 articles on the health consequences of structural adjustment, identifying a preponderance of findings of negative health effects, especially in Africa, but noting that a subset of 'empirical' studies (defined rather problematically) demonstrated both positive and negative effects. Since then, the literature has expanded considerably, including powerful fieldwork-based descriptions of adverse health effects in Peru (Kim, Shakow, Bayona, Rhatigan, and Rubin de Celis 2000), sub-Saharan Africa (Schoepf, Schoepf, and Millen 2000), the former Soviet Union after the application of neoliberal 'shock therapies' (Field, Kotz, and Bukhman 2000) and other countries and regions studied using ethnographic as well as epidemiological methods (Pfeiffer and Chapman 2010). Additional evidence comes from recent multi-country statistical studies of countries in sub-Saharan Africa, finding higher

child mortality rates during periods when countries were operating under World Bank, IMF or African Development Bank structural adjustment conditionalities (Pandolfelli and Shandra 2013; Shandra, Shandra, and London 2011; Shandra, Shandra, and London 2012), while recognizing the complexity of the relevant mechanisms of action and observing that child mortality is only one among many health outcomes of concern. Another recent multi-country study of the relation between IMF conditionalities and public spending on health found that per capita expenditure levels were actually higher in sub-Saharan African countries operating under conditionalities, but lower in low-income countries outside the region, whilst warning that other explanatory variables were also in play and that spending might still be seriously inadequate (Kentikelenis, Stubbs, and King 2015).

The question of adequacy of spending recurs. An aid-funded Canadian team tasked with helping to rebuild Tanzania's crumbling public health care system wrote in 2004 that: 'The era of structural adjustment may be over, but the effects of earlier damage continue to cast a long shadow' (de Savigny, Kasale, Mbuya, and Reid 2004, 10). In fact, there is abundant evidence that the era was not over. Throughout the first decade of the century the IMF insisted on strict limits to public expenditures on health and education, even when funds had been committed by donors, because of concerns about potential domestic inflation and about currency appreciation that would reduce the attractiveness of exports (Ambrose 2006; Ooms and Schrecker 2005; Working Group on IMF Programs and Health Spending 2007); the expenditure ceilings arguably contributed to debilitating shortages of health professionals in some countries (Korir and Kioko 2009). The health system impacts of structural adjustment temporarily came to broader public attention in the wake of the 2014 Ebola outbreak and the 'secondary health crises' that emerged in such areas as nutrition, malaria treatment and maternal care (O'Carroll 2014), with some commentators arguing that the weakness of many African national health systems was directly traceable to the legacy of IMF programmes (Kentikelenis, King, McKee, and Stuckler 2015; Rowden 2014); the IMF, predictably, contested the claim (Gupta 2015).

Structural adjustment, in the narrow sense of response to external lender conditionalities, represents a paradigm case of the strategic implementation of neoliberal policies, a manifestation of a pattern in which '[f]or the first time in history, capitalism [was] being adopted as an application of a doctrine, rather than evolving as a historical process of trial and error'(Przeworski et al. 1995, viii). It has been argued that at least for many LMICs, the globalisation of financial markets generates 'implicit conditionalities' that operate in similar ways (Griffith-Jones and Stallings 1995; Mosley 2003). The choice of a counterfactual is important. More or less by definition, economies and societies that experienced structural adjustment conditionalities did so because their current economic model was unsustainable, so a 'business as usual' counterfactual is implausible. If one accepts the Thatcherite dictum that there is (or was) no alternative to liberalisation, then the exercise of assessing health impacts is of limited value. If on the other hand one is prepared to consider a 'counterfactual [that] is a different sort of change from neoliberal change, let us call it for convenience's sake a social democratic model' (Huber and Solt 2004, 150), then the exercise is critical and raises broader questions about the political economy of health and the forces that define political feasibility.

Poverty, inequality, insecurity and the 'Great Risk Shift'

Wherever they have been implemented, neoliberal policies have increased economic inequality and insecurity, often accompanied by increases in poverty (however measured). Notably, in the United Kingdom after the election of Margaret Thatcher's Conservatives in 1979, the Gini coefficient¹ for incomes after taxes and transfers (the most relevant comparison if we are interested in the effects of public policy) rose from 0.27 in 1975 to 0.35 by 1990, and has continued to fluctuate around that level since then. Another way of stating the change is in terms of a shift from the level of income inequality found in contemporary (2012) Belgium to the level found in the United States by the end of the 1980s. In the United States, after the election of Ronald Reagan as president in 1980, the Gini

rose from 0.31 in 1980 to 0.37 by 1993, and has continued to rise more slowly since then.² Other measures, notably those that can take into account concentration of incomes at the top of the distribution, show more drastic increases in inequality (Alvaredo, Atkinson, Piketty, and Saez 2013). Recent analyses show that income inequality has been rising in most but not all OECD countries, although both the extent of increase and the starting point vary widely (Organisation for Economic Co-operation and Development 2011; 2015). They also show a broader trend of rising within-country economic inequalities in countries rich and poor alike (Birdsall 2006; Bourguignon 2015; UNCTAD 2014, 15-42).

Policy choices that reflect the ideological and programmatic dimensions of neoliberalism affect levels of poverty, economic inequality and insecurity in several ways, starting with the distribution of market incomes (that is, incomes before the effect of taxes and transfers). Governments may (as in the post-Thatcher UK) fail to support domestic manufacturing industry, historically the source of 'middle class' incomes throughout the high-income world for many with limited formal credentials. This set of policy choices is not discussed further here, although it should be noted that the trade and investment agreements that provide legal infrastructure for worldwide neoliberalisation place serious constraints on the ability of LMIC governments to use policy measures that were routinely used by today's high-income economies as they industrialised (Chang 2002). A comparative study of the prevalence of low-wage work in the wealthy world (Gautié & Schmitt, eds. 2010) found dramatic contrasts among countries that had 'all been exposed over the last several decades to the same increases in globalization, technology, and competition within national product markets' (Appelbaum et al. 2010, 5). There was a clear and unsurprising correlation with rates of unionisation and collective bargaining coverage, which respond to the characteristics of domestic industrial relations law regimes, with the highest prevalence of low-wage work found in the US and UK, both of which saw sustained attacks on trade unions starting *circa* 1980. At the other end of the income spectrum, it has been persuasively argued that the dramatic concentration of income at the top of

the US distribution is partly a consequence of changes in tax policy, creating a positive feedback loop that further magnifies the influence of the wealthy in politics (Hacker and Pierson 2005; 2010).

Beyond labour market policy, countries vary widely in whether and to what extent their policies mitigate the divergence in market incomes associated with sectoral and technological change and transnational economic integration (Dorling 2014; Piketty and Saez 2014).

Statistics on wage levels and incomes fail to capture a crucial dimension of the neoliberal turn in public policy. In the US context, Hacker (2008) described this as *The Great Risk Shift* in which labour market policies and social policy retrenchment combine to increase the economic insecurity of large segments of the population, as indicated by the frequency in the US (*before* the financial crisis) of personal bankruptcy and loss of homes to repossession, and rising chances of experiencing a drop of 50 percent or more in income over a two-year period. One important contributor to the risk shift was the changing nature of work, as employment growth was concentrated in low-wage jobs with variable hours and no benefits (Hacker 2008, 61-85; Handler and Hasenfeld 2007, 30-33, 238-281), leading to the emergence of precarious employment as a recognised category. This was the labour market into which millions of US residents, mainly women, were driven after welfare 'reforms' in 1996 shredded an already fragile safety net, ending a decades-long guarantee of minimal financial support to families with children in favour of time-limited benefits and strict 'workfare' requirements (Handler and Hasenfeld 2007; Seccombe 2009; Wacquant 2009, 76-109) – a shift that has been described as a domestic version of structural adjustment (Schleiter and Statham 2002). In the UK, neoliberal labour market transformations began in the Thatcher era with changes to labour law (continued under her New Labour successors) coupled with the privatisation of most major state-owned industries. By 2016, close to a million workers were on so-called zero hours contracts, many of them working multiple jobs to make ends meet (Morris 2016). The most drastic welfare reforms were to come later, as noted in the next section of the article.

By 2001, an extensive review identified 93 studies of the relation between precarious employment status and work-related illness and injury, with a clear preponderance of findings that precarious employment led to increased probability of adverse health outcomes associations (Quinlan, Mayhew, and Bohle 2001). A subsequent study that applied more restrictive inclusion criteria, resulting in greater reliance on longitudinal studies, and focused on employer 'downsizing' and other forms work reorganization that increase job insecurity reached a similar conclusion: '[T]here is now a substantial – even compelling – body of international evidence that downsizing and job insecurity have significant adverse effects on workers' health and well-being' (Quinlan and Bohle 2009, 5). A 2014 review that incorporated an explicit conceptual model of the relevant channels of influence and included research conducted after the economic crisis that began in 2007 likewise reached similar conclusions (Benach et al. 2014).

A further dimension involves the health consequences of economic inequality in entire societies. In *The Spirit Level*, Wilkinson and Pickett (2010) showed that several adverse health outcomes (life expectancy, infant mortality, adult obesity and child overweight) are more frequent in societies where economic inequality is higher. Multiple mechanisms of action are no doubt involved, but the identification of economic inequality as the primary concern draws strength from the fact that when Wilkinson and Pickett combined multiple indicators, including homicide rates, frequency of teenage births and imprisonment rates as well as the health outcomes cited, into a composite index of health and social problems, they found a very close correlation to inequality – suggesting the operation of processes that relate to the overall organisation of the society. A subsequent update (Pickett and Wilkinson 2015) that made explicit reference to several standard criteria for inferring causation in epidemiological studies (Hill 1965) and incorporated more recent research strengthened the argument. As the authors noted: 'The evidence that large income differences have damaging health and social consequences is already far stronger than the evidence supporting policy initiatives in many other areas of social and economic policy' (Pickett and Wilkinson 2015, 324).

The shift in social protection towards workfare, presuming that the jobs are out there like the truth on 'The X Files' (for refutations see among many other sources Handler and Hasenfeld 2007, 238-281; Shildrick, MacDonald, Webster, and Garthwaite 2012), exemplifies 'the process whereby a broad range of social issues is being reconstituted ... in highly individualized terms. Health care and poverty are treated as individual shortcomings, products of poor individual choices, to be remedied by emphasizing individual responsibility' (Fudge and Cossman 2002, 21). This process instantiates the interaction between ideology and programmes identified by Ward and England. It can operate directly in the health policy sphere, as when [then] UK Prime Minister Blair opined that many public health problems are 'not, strictly speaking, public health problems at all. They are questions of individual lifestyle - obesity, smoking, alcohol abuse, diabetes, sexually transmitted disease ... These are not epidemics in the epidemiological sense - they are the result of millions of individual decisions, at millions of points in time' ('Blair calls' 2006). The resulting 'lifestyle drift' in health promotion (Popay, Whitehead, and Hunter 2010) has pernicious implications when it ignores such factors as the simple unaffordability or inaccessibility of healthy diets for those on low incomes (Barosh, Friel, Engelhardt, and Chan 2014; Breyer and Voss-Andreae 2013; Drewnowski, Monsivais, Maillot, and Darmon 2007; Jones, Conklin, Suhrcke, and Monsivais 2014; Loopstra et al. 2015; Loopstra, Reeves, and Stuckler 2015; McIntyre, Bartoo, and Emery 2014; Monsivais and Drewnowski 2009; Perry, Williams, Sefton, and Haddad 2014; Williams et al. 2012), diverting attention from aspects of social position that make it far more difficult for some people to lead healthy lives than for others, even given best intentions and perfect knowledge. As it applies not only to health but also to social policy, this individualisation represents an especially destructive manifestation of the ideological dimension of neoliberalism as it colonises professional routines and policy vocabularies.

The financial crisis and the austerity response

The economic crisis that spread across the world in 2007 from an epicentre in the US was only possible because of decades of domestic deregulation of financial institutions in (especially) the US and UK, as they competed for status as global hubs for the financial services industry (Helleiner 1994) – policies that the industry had invested much time and treasure to advance (in the US context see e.g. Immergluck 2011). Among the most immediate impacts, officially reported unemployment levels in the US and UK roughly doubled from pre-crisis levels; worldwide, an estimated 35 million people lost jobs (Calvo 2010). The combination of crisis impacts and post-crisis austerity measures resulted in strikingly high youth unemployment levels: almost 25 percent across the entire Eurozone (Inman 2013) and 50 percent or more in some southern European countries. Both analytically and normatively, it is useful to compare the process with climate change: in each case, those first and worst affected have had no control over the policies that facilitated the crisis, and have limited or no ability to influence responses.

Over the short term, the health effects of the crisis and subsequent responses may not have been unambiguously negative ; the literature suggests that recession and rising unemployment may lead to reductions in mortality from some causes, as people drink less and drive less, whilst suicide rates are likely to increase (Bacigalupe, Shahidi, Muntaner, Martín, and Borrell 2016; Suhrcke and Stuckler 2012) as they have in Greece (Madianos, Alexiou, Patelakis, and Economou 2014). In a comprehensive assessment of the relevant epidemiological evidence *circa* 2012, Stuckler and Basu (2013) found that over the short term countries such as Iceland and the US that responded to the financial crisis of 2007 with an economic stimulus faring better, particularly in terms of mental health and suicides, than those countries (e.g. Spain, Greece and the UK) that pursued a policy of austerity (public expenditure cuts to reduce government debt). Post-crisis responses in many countries have increased inequality and insecurity through cuts in public sector budgets for health care and social protection, most immediately leading to increases in user charges for health services and prescription drugs (Burke, Thomas, Barry, and Keegan 2014; Karanikolos et al. 2013; Petmesidou

2013). An analysis for the European Parliament from a human rights perspective found that most EU member states had adopted measures that adversely affected health care access, with 'poor and homeless people, older people, people with disabilities and their families, women and undocumented migrants ... among the groups which were disproportionately affected' (Tamamovic 2015, 49). A major comparative research project on social and economic policies and health equity in 23 EU countries disaggregated the effects of unemployment and of austerity policies on overall mortality, accident mortality, suicide and cardiovascular disease, and found that whilst the health effects of unemployment were ambiguous or slightly positive, the effects of austerity were unambiguously negative (Borrell et al. 2015, 13-15), although the detailed supporting analysis has not been published at this writing.

Taking the UK as an example, the alleged imperative of reducing government debt and deficits through expenditure cuts was used to justify regressive welfare reform post-2010, including benefit cuts and rapid increases in the use of sanctions (threatened or actual withdrawal of payments) for non-compliance with workfare requirements (Loopstra, Reeves, McKee, and Stuckler 2015; O'Hara 2015a) designed to force the unemployed into the labour market 'irrespective of the quality of the work on offer' (Green and Lavery 2015, 911). The health impacts of exposure to an unpredictable, if not malicious regime of benefit withdrawal were described by several witnesses at a UK House of Commons hearing in 2015 (Mcdougall, Moriarty, Curtis, Thompson, and Gaze 2015). The literature does not appear to offer cross-national comparative research on such impacts. Qualitative accounts of the quotidian desperation that resulted (O'Hara 2015b) are complemented by concrete indications of negative effects on health, starting with reduced access to the healthy and adequate diet that is perhaps the most basic prerequisite for health. In the UK, one estimate is that 4.7 million people were living in 'food poverty' in 2013/14 (Centre for Economics and Business Research 2013); reliance on food banks is growing rapidly (Loopstra et al. 2015), with the workfare regime identified as a major contributing factor (Garthwaite, Collins, and Bambra 2015).

The latest (at this writing) of a unique series of assessments of national responses to the financial crisis including both high-income countries and others (Ortiz, Cummins, Capaldo, and Karunanethy 2015) noted that ‘in stark contrast to newspaper headlines and public perception Austerity is increasingly a developing country phenomenon’ (p.3), although more than three-fifths of the population in high-income countries were also affected. The review found that 107 governments were considering reducing social protection coverage; 89 governments were ‘considering some form of labour flexibilisation’; and health system reforms ‘being considered by 56 governments ... can include raising fees and co-payments for patients’ (pp. 12-13). Assessment of the long-term health consequences must await further research, but it is useful to consider parallels with the earlier era of structural adjustment (Ottersen et al. 2014, 638-640). In the extreme Greek case, austerity has been mandated by conditionalities attached to bail-outs from the ‘troika’ of the European Commission, the European Central Bank and the IMF. As in the 1980s and 1990s, primary beneficiaries are the commercial banks that hold the country’s debts (Stiglitz 2015), and alternative policy mixes that would involve different distributions of burdens and benefits (Ortiz, Cummins, and Karunanethy 2015) do not appear to have received serious consideration. It must be emphasised that many long-term (including intergenerational) health impacts of the crisis and subsequent austerity measures probably have yet to be observed. The study attributes a shift toward ‘fiscal consolidation’ to policy advice provided by the IMF, suggesting - as have earlier analyses (Lee and Goodman 2002; Sachs 1998) – that both the IMF and the World Bank are influential propagators of neoliberal ideology even beyond their role as lenders and ‘gatekeepers’. It may well be that a new era of structural adjustment and long-term austerity looms, with health consequences that have yet to be assessed adequately.

Trade and transnationals: Constitutionalising neoliberalism?

The axiomatic desirability of 'free trade' and the removal of restrictions on trade and investment are among the core elements of neoliberalism. At the start of the century, it was claimed that 'globalisation', defined in terms of increased openness to trade, 'is good for your health, mostly' because of associated increases in national income that make possible poverty reduction and investment in health systems (Feachem 2001). Both elements of this claim – the automatic linkage of trade with growth and the contribution of growth to poverty reduction – have now been challenged (Kawachi and Wamala 2007, 129-132; Nissanke and Thorbecke 2006; UNCTAD 2013a, 24-92); meanwhile, a substantial body of evidence on the actual and anticipated adverse health effects of liberalised trade and investment as accumulated.

Three points are essential to understanding these effects. First, with the 1993 North American Free Trade Agreement (NAFTA) and the coming into force of the World Trade Organization (WTO) regime in 1995, the focus of trade policy disciplines shifted from 'at the border' measures like tariffs and quotas to 'behind the border' domestic policies that can be viewed as restricting trade. The effect, and intent, is to limit governments' policy space: 'the freedom, scope, and mechanisms that governments have to choose, design, and implement public policies to fulfill their aims' (Koivusalo, Schrecker, and Labonté 2009, 105). Second, trade itself is no longer about arm's-length exchange of goods between two relatively autonomous national economies. On one estimate, 80 percent of world trade now involves complex commodity or value chains that operate across multiple national borders and are controlled by transnational corporations (TNCs)(UNCTAD, 2013b); development is increasingly contingent on the ability to attract foreign investment or outsourced contract production as part of these commodity chains. Third, superimposed on the WTO regime, which involves all the world's major economies, is an increasingly complex web of regional and 'mega-regional' trade agreements and bilateral investment treaties (BITs) that create additional limits on policy space. It has been argued that the effect of this web is to 'constitutionalise' neoliberalism, by

making policy departures increasingly difficult and potentially costly for governments and national economies (Schneiderman 2008).

The literature identifies several negative health consequences of these new trade policy modalities (for overviews see Friel, Hattersley, and Townsend 2015; Labonté, Blouin, and Forman 2009). Most familiar is the limitation on access to essential medicines associated with harmonisation of intellectual property protection under the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). Although the agreement has been interpreted to allow ‘flexibilities’ in patent regimes (’t Hoen, Berger, Calmy, and Moon 2011) and the world’s least developed countries have now been granted exemption from these provisions until 2033 (Saez 2015), the flexibilities have been used in only a limited number of cases (Beall and Kuhn 2012). This may be because of informal pressure from (in particular) the United States not to utilize these, or because ‘TRIPS-plus’ provisions in a variety of bilateral and regional agreements vitiate these flexibilities (Correa 2013, 903-904; Roffe, Von Braun, and Vivas-Eugui 2008; Shaffer and Brenner 2009). Meanwhile, the US and the European Union have actively pursued such TRIPS-plus provisions in negotiations now under way (Bloemen and Mellema 2014).

A substantial body of evidence links trade and investment liberalisation with the accelerated ‘diet transition’ that has resulted in rapid increases in overweight and obesity in LMICs – a perfect storm in terms of future health care system impacts and costs. The contemporary trade policy regime has reduced impediments to foreign investment in supermarkets, food processing and fast food and to imports of ‘ultra-processed foods’ (Clark, Hawkes, Murphy, Hansen-Kuhn, and Wallinga 2012; Goran, Ulijaszek, and Ventura 2013; Hawkes, Friel, Lobstein, and Lang 2012; Monteiro, Moubarac, Cannon, Ng, and Popkin 2013; Popkin 2007; 2014; Popkin, Adair, and Ng 2012). A strong association has been found between the level of foreign investment as a percentage of GDP, or the existence of a trade agreement with the US, and ‘consumption of unhealthy food commodities, especially for soft drinks, processed foods and alcohol’ across 50 LMICs (Stuckler, McKee, Ebrahim, and Basu 2012). This has

occurred in the context of a formidable corporate research and marketing apparatus dedicated to promoting ultra-processed food products that are highly profitable, but may be unhealthy (Moss 2013), and to resisting regulatory or even public information initiatives (see e.g. Freudenberg 2014, 37-123; Kearns, Glantz, and Schmidt 2015; Taubes and Couzens 2012). Comparisons with the power and tactics of the tobacco industry have been drawn at least since 2004 (Chopra and Darnton-Hill 2004), and transnational corporations have been described as the ‘vectors of spread’ of ‘industrial epidemics’ associated with alcohol and ultra-processed foods (Moodie et al. 2013).

In the area of environmental regulation, in numerous disputes the precautionary principle (Commission of the European Communities 2000) entrenched in many areas of European Union (EU) law has already come into conflict with the WTO Agreement on Sanitary and Phytosanitary Standards (SPS), which requires that protective measures be based on risk assessment and ‘available scientific evidence’ (McGrady 2011, 184-195). The effect is to superimpose a high and unpredictable standard of proof (McGrady 2011, 130-169) on domestic policies that reflect legitimate differences among societies about their tolerance for technological risk and the appropriate resolution of scientific uncertainty (Bergman et al. 2013; Rodrik 2011, 194-197). Even when a country might expect to be successful in trade dispute resolution processes on the merits of the issue, ‘[t]he potential for health protection measures to attract lengthy and costly trade disputes ... can lead to “policy or regulatory chill”’ (Friel et al. 2015, 329) – difficult to assess because of problems observing the operation of anticipated reaction (Tienhaara 2011), but potentially an especially serious concern for LMICs that do not have the EU’s budget or institutional capacity.

The most serious adverse health impacts of neoliberalism as embodied in trade policy probably lie in the future – a point emphasised in assessments of the Trans-Pacific Partnership (TPP), the negotiated text of which was released late in 2015 (Labonté, Schram, and Ruckert 2016),³ and of successive leaked drafts of the Transatlantic Trade and Investment Partnership (TTIP) between the

US and the EU (Koivusalo and Tritter 2014; Weiss 2015). Apprehensions about both agreements include regulatory chill – for example, as a result of ‘SPS-plus’ provisions that the EU is pursuing as part of the TTIP negotiations (European Commission 2013); further restrictions on access to medicines; and the possibility that future privatisations of core public services like the UK’s National Health Service (NHS) would become irreversible because of investor-state dispute resolution (ISDS) provisions. These provisions, which are included in a substantial fraction of the roughly 3,000 bilateral investment treaties (BITs) now in force globally, and in both TTIP and the TPP, epitomise the role of trade agreements as constitution for a neoliberal economic order. Generically, these provisions enable foreign investors to seek arbitration through one of several dispute resolution processes in situations where the actions of a host country government are alleged to have deprived them of profits, usually including future or anticipated profits (UNCTAD 2014, 137-140).

- Insert Figure 2 about here -

Both the number of agreements incorporating such provisions and the number of cases initiated by investors have increased rapidly in recent years (Figure 2). The lack of clear and binding definitions of key concepts such as indirect expropriation (e.g. through strengthened environmental regulation) allows investors, meaning in practice mainly TNCs (Van Harten and Malysheuski 2016), abundant opportunities for policy challenges, which if successful are normally not appealable and are enforceable through domestic courts (Gaukrodger and Gordon 2012; Singh and Sharma 2013). Such cases may take years to be resolved, and settlements may not be public, so it is difficult to assess the long-term implications for health, but ISDS provisions could be used, for example, to challenge minimum unit pricing for alcohol, taxes on unhealthy ultra-processed foods, or nutrition labelling (Thow et al. 2015). ISDS provisions also offer a way for pharmaceutical firms to defend their patents against compulsory licensing policies to improve access to medicines that would be permissible under TRIPS flexibilities – another dimension of the TRIPS-plus issue (Ruse-Khan 2011), and have also

been used – so far without success – to challenge national tobacco packaging and warning policies (Sud, Brenner, and Shaffer 2015). It is not yet possible to assess the longer-term health consequences of the current and evolving trade policy regime, but by the time epidemiology documents such consequences, the costs that would follow from changing the relevant agreements may mean that they are effectively irreversible.

Conclusion: A tale of two paradoxes

Much has been omitted from this review, for reasons of space. For example, it has not provided (and the literature does not offer) a systematic view of how political priorities that emphasise deregulation and business-friendliness have led to such consequences as fatal outbreaks of food-borne and water-borne infections that follow declines in inspection budgets or regulatory requirements (Attaran et al. 2008; Moss 2009; Snider 2003). The health consequences of the lack of effective regulation of extractive and manufacturing industries, especially outside the high-income world, may represent some of the most serious adverse health impacts of the worldwide diffusion of neoliberalism (see e.g. Bambas Nolen et al. 2014; People's Health Movement et al. 2014, 229-244; Popplewell 2009). It has also not examined the health consequences of 'financialisation' and the health consequences of capital flight that is facilitated by financial deregulation (Schrecker 2014). We conclude with the nearly obligatory academic call for more research, and with an examination of two (apparent) paradoxes in the study of neoliberalism and health.

First, despite the destructive effects of neoliberalism, in most jurisdictions where neoliberal policies have been applied, conventional health indicators such as life expectancy continue to improve, although health inequalities may widen (as for example in the UK). Only in cases of truly cataclysmic

social upheaval do we encounter actual decreases in life expectancy. A case in point is the experience of Russia after the collapse of the Soviet Union, where the application of an extreme form of neoliberalism in the form of economic ‘shock therapy’ (along with massive capital flight that continues to this day) resulted in a halving of economic output, social disintegration and a (temporary) decline of several years in male life expectancy (Field et al. 2000; Shkolnikov and Cornia 2000) – unprecedented in recent peacetime apart from the example of the HIV epidemic in sub-Saharan Africa. Thus, it cannot normally be argued that neoliberalism worsens the health of entire national populations, although it may well worsen the health of deprived or marginalised strata within those populations. It can be argued that neoliberalism has widespread adverse effects on health relative to the ‘social democratic counterfactual’ introduced at the start of the article. The political feasibility of such counterfactuals is beyond the scope of this paper.

There is some evidence from the US that this pattern of general improvement may be changing. Despite having by far the most expensive health care system in the world, which still left 33 million people uninsured for all of 2014 (Smith and Medalia 2015), the US ranks at or near the bottom relative to 15 high-income ‘peer countries’ on a range of *national level* health indicators (Woolf & Aron, eds. 2013), as well as exhibiting dramatic internal health inequalities. The connection with its high levels of poverty and economic inequality, and minimal social protections, is surely not implausible although a range of mechanisms are doubtless involved. And late in 2015, Case and Deaton (2015, 15078) pointed out ‘a marked deterioration in the morbidity and mortality of middle-aged white non-Hispanics ... after 1998’. An actual increase in all-cause mortality among this group stood in sharp contrast to six other high-income countries. The causes of death involved are suicide, drug and alcohol poisoning, and chronic liver diseases – the diseases of desperation. The pattern is (so far) distinctive to the United States, but the authors’ warning that ‘those currently in midlife may be a “lost generation” whose future is less bright than those who preceded them’ (Case and Deaton 2015, 15081) suggests the possibility of a more widespread, post-Soviet style health crisis. For

partially different reasons, such as the long-term health and social consequences of high (over 50 percent) and persistent levels of youth unemployment, a similar outcome may be in store for some of the jurisdictions hit hardest by the combination of the financial crisis and post-crisis austerity measures.

The second paradox is widely referred to in the literature as the Nordic (or Scandinavian) paradox. Given what is known about the social determinants of health, it might be expected that societies with relatively generous and redistributive social provision and lower levels of poverty and economic inequality, exemplified by the Scandinavian or Nordic welfare states, would have lower internal health inequalities. However, an extensive body of research (for reviews see Bambra 2007; 2011; 2013; Mackenbach 2012; Popham, Dibben, and Bambra 2013), much of it classifying welfare states using Esping-Andersen's (1990) admittedly contested three-fold typology, fails to support this hypothesis. Although such welfare states perform better on national-level population health indicators, as one would expect from the work of Wilkinson and Pickett, they do not exhibit lower levels of health inequality, although health inequalities on many measures are highest in jurisdictions that have experienced the full force of neoliberalisation. Several explanations may account for this, including the reliance of many studies either on self-reported health or on crude indicators such as life expectancy; greater inequality in some health-destructive behaviours such as smoking; and the limitations of the comparative typology itself. Leading authors in this field have recently called for the establishment of a health inequalities data infrastructure comparable to the Luxembourg Income Study as 'the TOP PRIORITY for new science on these critical questions' (Bambra and Beckfield 2012, 32; emphasis in original). It is not clear how this infrastructure would address such questions as the health impacts of trade policy. Further, whether finer-grained understandings of the mechanisms underpinning health inequalities are likely to lead to policies that reduce them effectively is, again, a political question outside the scope of this article.

Notes

¹ A standard, although only partial measure of inequality.

² OECD income distribution data from <http://stats.oecd.org/Index.aspx?DataSetCode=IDD#>.

³ This was the first published assessment to rely on the actual text, rather than on leaked versions of negotiating texts in progress (e.g. Gruszczynski 2015; Kapczynski 2015; Smith 2015)

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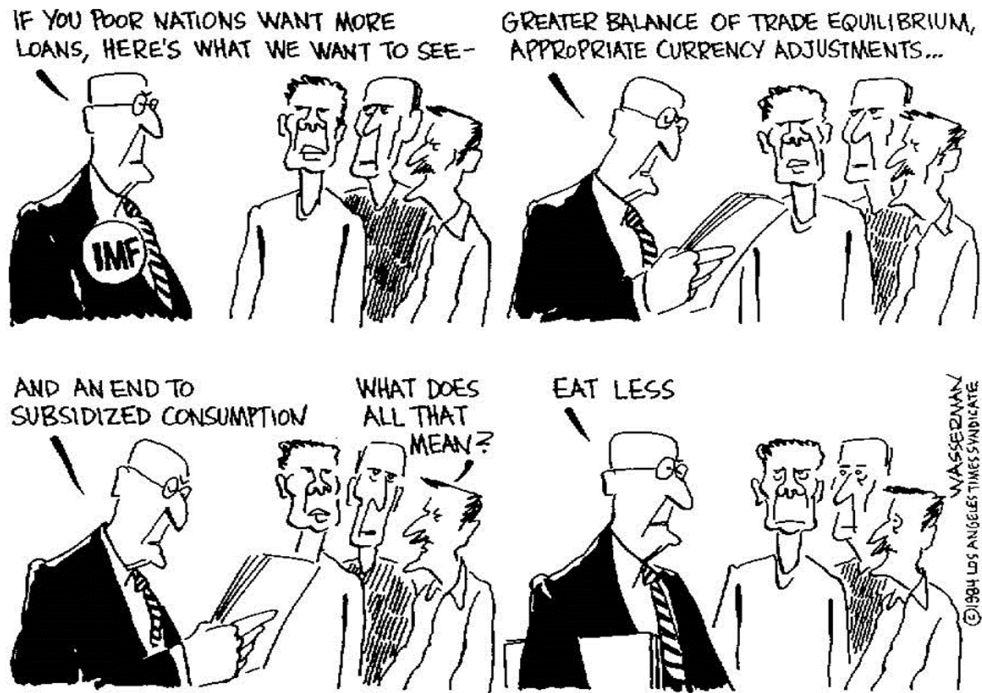
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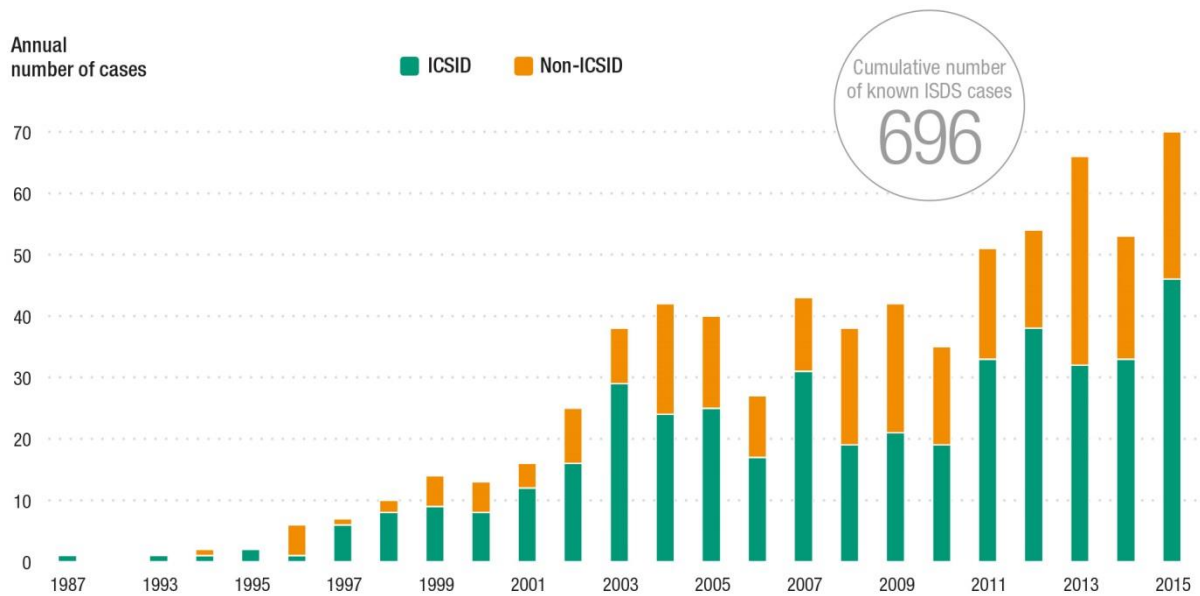
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Figure 1. A wise view of structural adjustment, from 1984



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Figure 2. Known ISDS cases, annual and cumulative, 1987-2015



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