HAL
open science

The Policies-Inequality Feedback and Health: the Case of Globalization

Roberto de Vogli, David Gimeno, Ritesh Mistry

To cite this version:

Roberto de Vogli, David Gimeno, Ritesh Mistry. The Policies-Inequality Feedback and Health: the Case of Globalization. Journal of Epidemiology and Community Health, 2009, 63 (9), pp.688-n/a. 10.1136/jech.2008.081588 . hal-00477879

HAL Id: hal-00477879

https://hal.science/hal-00477879v1

Submitted on 30 Apr 2010

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

The Policies-Inequality Feedback and Health: the Case of Globalization

Roberto De Vogli, PhD, MPH [1 2], David Gimeno PhD [1], Ritesh Mistry PhD MPH[4]

[1] International Institute for Society and Health, Department of Epidemiology and Public Health, University College London

[2] Globalization and Health Knowledge Network, World Health Organization (WHO) Commission on Social Determinants of Health

[3] Division of Occupational and Environmental Health Sciences, San Antonio Regional Campus of the University of Texas School of Public Health, Health Science Center at Houston

[4] Division of Cancer Prevention and Control, University of California Los Angeles

Words text: 1,942
Words abstract: 184

Figures: 1
References: 40

Correspondence to: Roberto De Vogli, International Institute for Society and Health, Department of Epidemiology and Public Health, University College London. 1-19 Torrington Place, London WC1E 6BT, (email: r.devogli@ucl.ac.uk).

Abstract

The hypothesis that economic inequality is a key determinant of population health is controversial, despite the balance of evidence suggesting that unequal societies have worse health outcomes compared to more egalitarian ones. Two major explanations have been proposed for the association between economic inequality and health: material deprivation and psychosocial factors. Although research has mainly concentrated on the plausibility of these two explanations, some contributors have highlighted the policy context influencing both economic inequality and health. These contributors have mainly concentrated on welfare regimes and neo-liberalism in affluent societies and conceptualized economic inequality mostly as a mere effect of policy reforms. In this article, we highlight the reciprocal causation between public policies and economic inequality and their connections to material and psychosocial pathways leading to health outcomes. As a case study, we analyse the two-way relationship between globalization-inequality and examine evidence on their effects on health at the global level. We argue that public policies and economic inequality are inextricably interconnected; therefore, in order to analyse the health effects of the former, it is necessary to take into account the latter, and vice versa.

Introduction

Whether and how economic inequality influences population health has been and still is the centre of important debates in the literature [1,2,4,5]. In spite of the ongoing controversies, evidence shows that more unequal societies have a host of worse health outcomes compared to more egalitarian ones [3]. The most common proposed mechanisms by which inequality affects health are material deprivation [4] and psychosocial factors [5]. Research on the health effects of inequality and the plausibility of these two explanations have generated important breakthroughs, however relatively little attention has been paid to the interrelations between policies and economic inequality, and how they influence health. Navarro and Shi [6] studied the effects of political traditions in the advanced OECD nations and concluded that social democratic governments with stronger welfare and redistributive policies had better health outcomes. Coburn [7] showed that the extent to which developed nations have adopted neo-liberal policies predicted their levels of inequality, poverty and health inequality. These contributors have expanded scientific understanding of the role of welfare regimes [6] and neo-liberalism [7] in influencing both income inequality and health in industrialised nations. However, economic inequality is not just a mere consequence of welfare regimes and neo-liberal policies, but can also act as a potential determinant of policies [1,8,9,10] influencing health-related outcomes. Furthermore, little work has examined the economic inequality hypothesis in the context of the broader set of globalization policies that have produced pervasive health effects especially in developing and transitional economies [11]. In this article, we propose a framework examining the reciprocal interrelations between policies and economic inequality and their consequences to health outcomes. We

also examine the paths linking these two factors to material deprivation and psychosocial factors and health. As a case study, we examine the two-way relationship between globalization and economic inequality and interpret evidence on their effects on health outcomes at the global level.

A Conceptual Framework

The framework (Fig. 1) describes how both policies and economic inequality can influence health through indirect paths involving material deprivation, psychosocial factors or both. The arrows do not represent all possible linkages between factors, but the most predominant ones. Rather than concentrating on how material deprivation and psychosocial factors affect health, associations widely studied in the literature [4,5], our framework emphasizes the policies-inequality feedback. On the one hand, policies can influence inequality through redistribution of wealth and income to the wealthy elites (e.g tax breaks) at the expense of the general population and the poor in particular (through material deprivation). Pro-rich policies can cause poverty or limit its reduction through less generous welfare regimes, lower public health expenditures and weaker labour market policies [6,7], but also financial deregulation [12], large-scale privatization [13] and trade liberalization [14]. On the other hand, economic inequality can influence policy formation (and further increase economic inequality) by generating a "democratic deficit" such as inequalities in political participation. Political campaign financing disproportionately comes from the wealthy elites [15], who use their influence to skew public policies around their special interests at the expense of policies designed to respond to the needs of the general population and the poor in particular [9]. For example, between 1991 and

2001, the top 41 TNCs in the United States (e.g. Microsoft, General Electric, Disney) contributed $150 million to political parties and campaigns and enjoyed $55 billion in tax breaks in only three years [16]. Economic inequality can also generate a "democratic deficit" through disinformation and manipulation of public opinion [17] by the same wealthy elites that own and control media [18] and can better influence the policy agenda of governments. Regressive public policies resulting from a "democratic deficit" and inequalities can obviously affect material deprivation, a major determinant of health [4]. Economic inequality, however, can also lead to pro-rich public policies via psychosocial factors including civic disengagement, political distrust and reduced voting participation [19], especially among the poor [8]. Through psychosocial factors, inequality can finally affect health outcomes by decreasing solidarity and increasing distrust, stress and hierarchical social comparisons leading to anti-social (e.g. crime) and unhealthy behaviours, negative emotions and biological reactions [5]. Rather than producing single, isolated effects, public policies, inequality, material deprivation and psychosocial factors seem to interact with one another creating complex paths leading to a wide range of health outcomes.

[Figure 1]

The Case of Globalization

The framework can be helpful to understand the two-way relationship between globalization policies and economic inequality and how they both affect global health. The late 70s and early 80s were periods characterised by the combined rise of a global financial system dominated by transnational

corporations (TNCs) and the introduction of disequalising policy reforms called the "Washington Consensus." [20] These policies included financial deregulation, trade liberalization, privatization of state enterprises, flexibilization of the labour market and reductions of public expenditures for health and social welfare. The reforms, implemented by international financial institutions such as the International Monetary Fund (IMF) and the World Bank, have been designed around the interests of TNCs and the most affluent nations. As a result, the share of Gross Domestic Product (GDP) controlled by TNCs grew from 17% in the mid-1960s to 33% in 1995 and, in the same year, two-thirds of world trade was carried out by TNCs [21]. Today, TNCs comprise more than a half of the top 100 world economies [22] and fewer than ten of them dominate the global media market [18]. Such enormous concentration of wealth and power has allowed TNCs to further advance policies of the "Washington Consensus" such as deregulation and privatization on the majority of countries through the IMF and World Bank. TNCs have also enormously increased their influence over national governments, especially through financial liberalization. TNCs have now the power to cause financial crises just by withdrawing investments and capital from countries that adopt "unfriendly policies" such as redistributive taxation. For 1999 as a whole, American TNCs had $400 billion of untaxed earnings in offshore heavens. By the end of 2002, the amount was about $639 billion. In 2007, about one third of the wealth of the world "high net worth individuals" (more than US$ 14 trillion out of US$ 43.5 trillion) was held legally offshore [23].

The feedback between globalization and the accumulation of wealth and power among TNCs is key to understand the increase of economic inequalities between and within countries. While economic inequalities were declining

worldwide between the 50s and the 70s, they have increased since the beginning of the so-called economic globalization era [24]. Between 1975 and 2005, the headline tax rate on corporate income of advanced OECD countries fell on average from around 50% to around 30% [25]. While the top family income quintiles increased their income, the bottom quintile experienced a slow but steady erosion of income [26]. After more than two decades of these policies, the richest 2% of adults in the world now own half of global household wealth while 50% of the world's adults own just 1% of global wealth. The Gini coefficient for world wealth has increased to 0.89, a "value one would obtain in a population of ten people if one person had $US1,000 and the other nine had just $US1" [27].

The reciprocal effects of globalization and inequality produced adverse health outcomes between and within societies. A recent study estimated that the rise of inequality during the widespread adoption of the Washington Consensus policies has reduced potential gains in life expectancy at birth by 1.23 years worldwide [28]. Gaps in life expectancy between countries have widened and after a sustained period of global health convergence. A pattern of divergence took place after the 80s as life expectancy fell in sub-Saharan Africa and Eastern Europe [29]. Within some rich nations such as New Zealand, progressive welfare policies have, to some extent, contrasted the effects of economic globalization and economic inequality, and stopped the rise of health inequalities [30]. In spite of these exceptions, however, health inequalities have continued to widen in most advanced nations [31].

With regard to the potential pathways connecting the globalization-inequality feedback and health, the prescriptions of the Washington Consensus have produced disappointing results both in terms of poverty reduction and

economic growth [32, 33]. These reforms were particularly disastrous in sub-Saharan Africa where the number of people living in poverty almost doubled [11] and in Russia where while poverty and unemployment skyrocketed [34], state assets have been "privatized" in the hands of a few oligarchs in the early stages of the so called "shock therapy" (a particularly radical version of the Washington Consensus package.) In 2004, a combined wealth of the 26 Russian billionaires in 2004 was 19% of the Russian GDP [27]. Excessive inequalities seem to act as a filter limiting growth as well as the potential benefits of growth for the poor [35]. The failure of the Washington Consensus is further corroborated by evidence from China [36] and the other Asian "tigers" including Taiwan [37]. These countries by not following the orthodoxy of the IMF and World Bank have generally succeeded in combining economic growth and poverty reduction.

When considering psychosocial factors, the skyrocketing economic inequalities of the globalization era have produced growing political distrust and disempowerment as shown by voter surveys in Britain, Italy, Spain, Belgium, the Netherlands, Norway, Sweden, Ireland and Japan [38]. Similarly, in the United States in 2004 almost two thirds of citizens agreed that their government is run by a few big economic interests looking out for themselves [39]. The "democratic deficit" resulting from the globalization-inequality feedback is perpetuated by the increasing global monopolization of media control [18] and corresponds with a further consolidation of the Washington Consensus policies now widely adopted, with a few exceptions (especially in Latin America), across both "left" and "right" political spectrum. A revealing example of the psychosocial effects of economic globalization and inequality is the rapid obesity epidemic in virtually any country of the world as trade liberalization policies allowed heavily subsidised TNCs to

penetrate foreign markets and virtually monopolize them [40]. The deleterious psychosocial effects of globalization and economic inequality have perhaps been experienced most clearly in Russia where sense of distrust, powerlessness, unhealthy behaviours, crime rates and suicide following the economic transition heavily contributed to cause one of the worst mortality crises in human history [34].

Conclusion

The controversies on the plausibility of the economic inequality hypothesis and the heated debates over the predominance of the material deprivation versus psychosocial pathways have largely dominated the literature on economic inequality and health. However, little attention has been paid to the interrelations between public policies and economic inequality and how such interrelations have affected health. When policies have been considered, inequality has been dismissed as a mere consequence of policies. However, inequality is not just an effect of policies, but can also be a causal factor. A revealing example is the globalization-inequality feedback: while, one the one hand, the Washington Consensus policies have facilitated the rise of TNCs and generated widening economic inequalities, the disproportionate economic power of TNCs (and resulting inequalities) played a key role in undermining democracy and pushing forward the reforms of the Washington Consensus through the IMF and the World Bank and national governments. The reciprocal interrelations between policies and economic inequality have reduced worldwide gains in life expectancy and widened health inequalities between and within countries, through different pathways involving both material deprivation and psychosocial factors.

Future research needs to avoid studying social factors in isolation, especially when they are closely related. This can produce misleading results where there are complex mechanisms of feedbacks at play. Policies and inequality, material deprivation and psychosocial factors are inextricably interrelated and they can all get "under the skin" through multiple, indirect, reciprocal pathways.

Policy Implications

- Pro-rich public policies and high economic inequality are inextricably interconnected and they can negatively influence health through multiple, indirect feedbacks.
- A revealing example is the complex set of feedbacks between the globalization policies of the Washington Consensus and the exaggerated concentration of economic power in the hands of TNCs. The reciprocal effects of these two factors have reduced gains in life expectancy and widened health inequalities worldwide.
- In order to promote health, it is crucial to address excessive concentrations of economic power (and the resulting "democratic deficit") that hinders the adoption of public policies that can promote health through mechanisms of redistribution of income and wealth.

References

1. Clarkwest A. Confounding and Process-Model Fit in Research on Income Inequality and Population Health. Social Science & Medicine 2008;66:1903-1908.
2. Zimmerman FJ. A Commentary on "Neo-Materialist Theory and the Temporal Relationship Between Income Inequality and Longevity Change. Social Science & Medicine 2008;66:1882-1894.
3. Wilkinson RG, Pickett KE. Income inequality and population health: a review and explanation of the evidence. Soc Sci Med 2006;62:1768–78.
4. Lynch, JW, Davey-Smith G, Kaplan K and House J. Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions. BMJ, 2000; 320:1200-4.
5. Marmot M, Wilkinson RG. Psychosocial and material pathways in the relation between income and health: a response to Lynch et al. BMJ, 2001; 322:1200.
6. NavarroV and Shi L. The political context of social inequalities and health. Social Science & Medicine 2001 52, 481–491.
7. Coburn D. Beyond the income inequality hypothesis: class, neo-liberalism and health inequalities. Social Science & Medicine 2004; 58:41-56.
8. Hill K and Lieghley J. The policy consequences of class bias in state electorates. Am J Political Sci 1992;36:351-365.
9. Ferguson T. Golden Rule: The Investment Theory of Party Competition and the Logic of Money-Driven Political System. 1995.
10. Blakely T, Kennedy B, and Kawachi I. Socioeconomic Inequality in Voting Participation and Self-Rated Health. Am J Public Health 2001;91:99-104.
11. Schrecker T, Labonte R, De Vogli R. Globalization and Health: the Need for a Global Vision. Lancet 2008; 372:1670-76.
12. Jerzmanowsky M and Malhar N. Financial Development and Wage Inequality: Theory and Evidence. MPRA Paper N. 9841, JEL Classification E25, J31, G24, 2008.
13. Milanovic B and Ersado L. Reform and Inequality during the Transition: an analysis using panel household survey data, 1990-2005. The World Bank, Policy Research Working Paper 4780, 2007.
14. Hanson G and Harrison A. Trade Liberalization and Wage Inequality in Mexico. Industrial and Labour Relations Review 1999;52(2):271.
15. Verba S, Lehman Schlozman K, Brady H. Voice and Equality: Civic Voluntarism in American Politics. Cambridge, Mass: Harvard University Press, 1995.
16. Institute on Taxation & Economic Policy, Citizens for Tax Justice and Public Campaign. Buy Now Save Later: Campaign Contributions and Corporate Taxation, 2001 available at www.itepnet.org/camptax.pdf.
17. Petrova M. Inequality and media capture. J Public Economics 2008 92;(1-2):183-212.
18. McChesney R. The political economy of the media: enduring issues, ermerging dilemmas. New York: Monthly Review Press, 2008.
19. Uslaner E and Brown M. Inequality, trust and civic engagement. American Politics Research 2005;33:868.
20. Robinson W and Harris J. Towards a global ruling class? Globalization and

the transnational capitalist class. Science & Society 2000;64(1):11-5411.
21. United Nations Conference on Trade and Development (UNCTAD). World Investment Report, 1996. United Nations/UNCTAD, 1996.
22. Anderson S and Cavanagh J. Top 200: the rise of corporate global power. Washington DC: Institute for Policy Studies, 2000.
23. Brittain-Catlin W. Offshore: the dark side of global economy. New York: Farrar, Straus and Giroux, 2005.
24. Dorling D, Shaw M, Davey-Smith G. Global inequality of life expectancy due to AIDS. BMJ 2006;322:662-664.
25. Ganghof S. The politics of income taxation: a comparative analysis. Colchester: ECPR Press, 2006.
26. Smeeding T. Globalization, Inequality and the Rich Countries of the G-20: Evidence from the Luxembourg Income Study (LIS). Working paper No. 48, Center for Policy Research, 2003.
27. Davies J. Personal Wealth from a Global Perspective. Oxford, UK: Oxford University Press, 2008.
28. Cornia A, Rosignoli S and Tiberti L. Globalization and Health: Impact Pathways and Recent Evidence. Globalisation and Health Knowledge Network Synthesis Paper. WHO Commission on Social Determinants of Health, 2007.
29. Moser K, Shkolnikov V and Leon D. World mortality 1995-2000: divergence replaces convergence from the late 1980s. Bulletin of the World Health Organization 2005;83:202-209.
30. Blakely T, Tobias M and Atkinson J. Inequalities in mortality during and after restructuring of the New Zealand economy: repeated cohort studies. BMJ 2008;336:371-375.
31. Machenbach JP, Bos V, Andersen O, Cardano M, Costa G. Harding S et al. Widening socioeconomic inequalities in mortality in six Western European countries. Int J Epidemiol 2003;32:830-7.
32. Labonte R, Blouin C, Chopra M et al. Towards health-equitable globalization: rights, regulations and redistribution. Globalization Knowledge Network final report to the Commission on Social Determinants of Health. Ottawa: Institute of Population Health, University of Ottawa, 2007.
33. Wade H. Is Globalization Reducing Poverty and Inequality? World Development 2004;32(4):567-589.
34. Walberg P, Mc Kee M, Shkolnikov V, Chenet L and Leon D. Economic change, crime, and mortality crisis in Russia: regional analysis. BMJ 1998;317:312-8.
35. Nissanke M. Channels and Policy Debate in the Globalization-Inequality-Poverty Nexus. World Development 2006;34(8):1338-1360.
36. Milanovic B. The two faces of globalization: against globalization as we know it. World Development 2003;31(4):667-683.
37. Chiang T. Economic transition and changing relation between income inequality and mortality in Taiwan: regression analysis. BMJ 1999;319:1162-1165.
38. Klingemann HD and Fuchs D. Citizens and the State. New York: Oxford University Press, 1995.
39. American National Election Studies (ANES), The ANES Guide to Public

Opinion and Electoral Behaviour: is the government run for the benefit of all, 1964-2004. ANES website http://www.electionstudies.org/index.htm.
40. Chopra M. Tobacco and obesity epidemics: not so different after all? BMJ 2004;328:1558-60.

Funding:

None

Competing Interests:

None

Statement:

The Corresponding Author has the right to grant on behalf of all authors and does grant on behalf of all authors, an exclusive licence (or non-exclusive for government employees) on a worldwide basis to the BMJ Publishing Group Ltd and its Licensees to permit this article (if accepted) to be published in Journal of Epidemiology and Community Health and any other BMJPGL products to exploit all subsidiary rights, as set out in our licence (http://jech.bmj.com/ifora/licence.pdf).

Contributions:

RD has been responsible for conception and design, analysis and interpretation of data and drafting of the manuscript. DG and RM have been responsible for the interpretation of the data and critical revision of the manuscript.
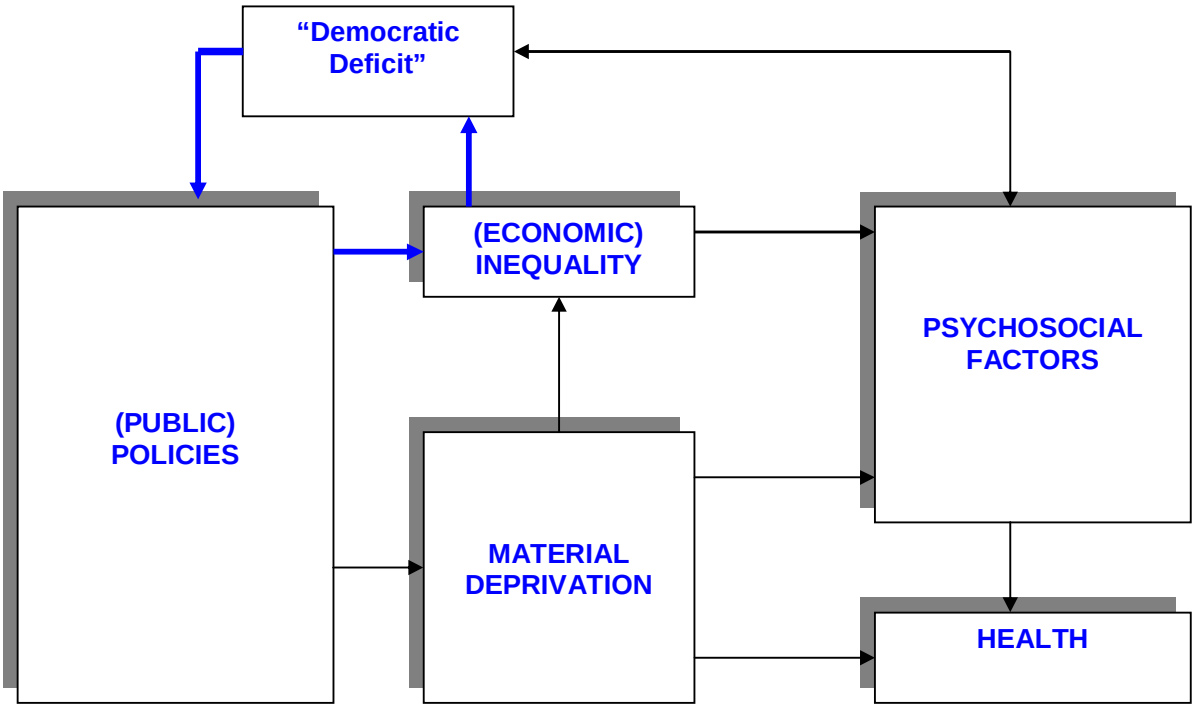
Figure 1. Framework of the Policies-Inequality Feedback and Health Via Material Deprivation and Psychosocial Factors.