



Health inequities in the age of austerity: The need for social protection policies



Arne Ruckert^{*}, Ronald Labonté

University of Ottawa, School of Epidemiology, Public Health and Preventive Medicine, 850 Peter Morand Crescent, Ottawa, ON K1G 5Z3, Canada

ARTICLE INFO

Article history:

Received 20 October 2016

Received in revised form

13 March 2017

Accepted 15 March 2017

Available online 18 March 2017

Keywords:

Health inequities

Austerity

Social determinants of health

Social protection

ABSTRACT

This commentary assesses the impacts of the global austerity drive on health inequities in the aftermath of the global financial crisis of 2008. In doing so, it first locates the origins of austerity within the 40 year history of neoliberal economic orthodoxy. It then describes the global diffusion of austerity since 2008, and its key policy tenets. It next describes the already visible impacts of austerity-driven welfare reform on trends in health equity, and documents how austerity has exacerbated health inequities in countries with weak social protection policies. We finally identify the components of an alternative policy response to the financial crisis than that of austerity, with specific reference to the need for shifts in national and global taxation policies and public social protection policies and spending. We conclude with a call for a reorientation of public policy towards making human health an overarching global policy goal, and how this aligns with the multilaterally agreed upon Sustainable Development Goals.

© 2017 Elsevier Ltd. All rights reserved.

1. Introduction

The 2008 Global Financial Crisis (GFC) triggered the deepest global recession since the Great Depression in the 1930s. The repercussions of the crisis were, and continue to be, felt worldwide. Shortly after its onset, many commentators predicted that, as with prior regional financial crises, the GFC would result in negative and disequalizing social and economic impacts, compromising major social determinants of health (SDH) and producing harmful health impacts, particularly on mental health (Banoob, 2009; Labonté, 2009; Marmot and Bell, 2009). In the same year as the crisis struck, the WHO Commission on Social Determinants of Health released its final report, calling for action on social determinants of health to address health inequities (WHO Commission on Social Determinants of Health, 2008). The report argued that a toxic combination of poor social policies and programmes, unfair economic arrangements and bad politics were responsible for a major part of health inequities, defined as systematic differences in health between and within countries which are avoidable by reasonable action, including a reduction in inequalities in the distribution of

socio-economic factors (or structural determinants of health) through targeted social policy interventions, such as progressive taxation policy and government subsidies for health-promoting goods and services.

In this commentary, we discuss the health impacts of the global austerity drive that governments adopted (or were compelled to adopt) shortly after the GFC. The commentary first locates the origins of austerity within the almost 40 years of a dominant neoliberal economic orthodoxy. It then describes the global diffusion of austerity in the aftermath of the GFC and its key policy tenets. We next summarize the known and potential future effects of austerity budgets, welfare reforms and other policy measures on health equity, by drawing on previous and current data and research in this area with a focus on how austerity measures might inequitably impact social determinants of health pathways. We describe the already visible impacts of austerity-driven welfare reform on trends in health equity, and document how austerity has exacerbated health inequities in countries with weak social protection policies. We then identify the components of an alternative policy response to the financial crisis with specific reference to the need for shifts in national and global taxation policies and public social protection policies and spending. Despite the increasing evidence that neoliberalism and its post-crisis austerity agenda is failing even on its own theoretical terms (i.e. to reduce government debt and stimulate economic growth), such evidence has yet to shift noticeably the austerity policy reform efforts led by the

^{*} Corresponding author. University of Ottawa, School of Epidemiology, Public Health and Preventive Medicine, 850 Peter Morand Crescent, Room 113, Ottawa, ON K1G 5Z3, Canada.

E-mail addresses: aruckert@uottawa.ca (A. Ruckert), rlabonte@uottawa.ca (R. Labonté).

European Central Bank, the European Union, and the international financial institutions (IFIs) (Lawson, 2016). We conclude with a call for a radical reorientation of public policy towards making human health an overarching global policy goal, and how this aligns with the multilaterally agreed upon Sustainable Development Goals.

2. A short history of neoliberal austerity

It would be a gross misconception to attribute the beginnings of the politics of austerity to the GFC and its recent effects. Rather, the origins of the current austerity drive can be traced back to the early 1970s, a period of economic stagnation and profit decline amidst a third world debt crisis and run-away inflation (Labonté and Stuckler, 2016). This led to the development of a policy consensus in the corridors of power (often referred to as the Washington Consensus) broadly aligned with neoliberal economics and its focus on privatization, deregulation, tax reform (i.e. lower corporate and income tax rates to attract foreign investment), trade and financial liberalization, and deficit reduction (usually understood as reducing budget deficits in economic downturns by decreasing public expenditure, particularly through welfare spending cuts) (Williamson, 2004). The driving forces behind this new consensus were Conservative governments which ascended to power in the early 1980s, including Ronald Reagan in the United States and Margaret Thatcher in the UK. The main pillars of this emerging neoliberal economic paradigm were reduction of growth in government spending, reduction of the federal income and capital gains taxes, trade and investment liberalization and tightening of monetary supply.

Structural adjustment policies (SAPs) were the tools used by the International Monetary Fund (IMF) and World Bank to bring developing countries into alignment with the neoliberal paradigm, while multilateral trade agreements, eventually culminating in the 1995 World Trade Organization, further morphed the welfare state into the competitive state (McBride et al., 2016). Beginning in the early 1980s SAPs were widely introduced across the developing world, and by 1987 the World Bank had approved 52 structural adjustment loans and 70 sectoral adjustment loans. During the period 1980–89, 171 SAPs were introduced in sub-Saharan Africa alone (Ruckert et al., 2015). These transformations had, and continue to have, significant implications for health equity both nationally and globally (Ruckert and Labonte, 2012). While neoliberal policy implementation differed in varying country contexts, it generally included the progressive dismantling of the welfare state, in terms of its fiscal capacity and its related ability to engage in social spending (Benatar et al., 2011). It was one of the primary goals of SAPs to eliminate, or at least significantly reduce, budget deficits in order for countries to meet their international debt obligations, and to return those countries at risk of sovereign default to a balanced budget position over time. In many countries, this meant significant cuts to healthcare and other health-relevant social services spending. Such spending cuts were often accompanied by revenue-generating schemes that required users to share in the cost of services, further undermining equitable access to health care and impoverishing households (McIntyre et al., 2006). As one example, Ghana's Economic Recovery Programme of 1983–1986 required the removal of general subsidies, which led to an intensification of fee collection for services and enforcement of the Hospital Fees Act (Bhattacharya et al., 2002).

3. The global financial crisis and the deepening of austerity

The GFC, rather than generating an abdication of neoliberal economics, quickly led to an intensification of its austerity regime. In the direct aftermath of the crisis, most governments and

international organizations, including the IMF and the World Bank, acknowledged the importance of counter-cyclical fiscal spending in response to the collapse of effective demand and trade, depressing global economic growth (Ruckert and Labonté, 2012). For a brief period between 2008 and 2009, most governments around the world introduced fiscal stimulus programs and ramped up public spending. According to an expenditure review by UNICEF, when comparing pre-crisis spending levels to this first phase, 80% of countries (144 in total) had increased public expenditures, with the average expansion amounting to 3.9% of GDP (Ortiz and Cummins, 2013). But by 2010, as the private debt crisis turned into a sovereign debt crisis, austerity was back on the agenda, heralding the beginning of the second phase of the crisis response (2010–2013). It was again the IFIs that took the lead in implementing austerity in the developing world through linking access to emergency finance to a new set of structural adjustment programs very reminiscent of the discredited programs of the 1980s and 1990s (Ruckert and Labonté, 2012).

In this phase, despite the fragile state of economic recovery with relative poverty, averaging globally around \$2.90/day in consumption according to World Bank metrics, on the rise, governments started to withdraw fiscal stimulus programs and scale back public spending. When comparing expenditure levels in the second phase of the crisis (2010–12) to the expansionary phase (2008–09), 40 percent of countries (or 73 in total) reduced total spending by 2.3 percent of GDP, on average, with fiscal contraction strikingly larger among developing countries: 56 developing countries cut their budgets by an average of 2.7 percent of GDP compared to 17 high-income countries at 1.0 percent of GDP (Ortiz and Cummins, 2013). In the third phase (2012–2015), austerity has somewhat slowed despite various predictions initially that the number of countries affected by spending cuts would jump even further, and that the average contraction size would increase by 2015 (Ortiz and Cummins, 2013). The worldwide drive toward austerity temporarily waned beginning in 2012. During the four year period between 2012 and 2015, a number of countries eased policies to cut expenditures, with 86 countries worldwide continuing to cut their budgets during this phase, but at an overall slower pace. However, recent IMF expenditure projections for 2016–2020 indicate that austerity will likely ramp up significantly beginning in 2017, suggesting that austerity will affect more than 6.1 billion persons or nearly 80 per cent of the global population by 2020 (Ortiz et al., 2015). Ortiz et al. note that compared to a baseline scenario without spending contraction, global GDP will be 5.5 per cent lower by 2020 than without austerity (Ortiz et al., 2015).

The central tenets of austerity encompass policy changes with direct and indirect health equity implications. Directly health relevant aspects include the rationalization and further targeting of social safety nets and social protection spending; health care system reforms to constrain rapidly expanding health budgets; the elimination or reduction of subsidies, for example for food and agricultural inputs; and reforming of age-old pensions through raising of contribution rates and lowering of paid-out benefits (Ruckert and Labonte, 2012). Of indirect health relevance are labour market reforms to further increase labour market flexibility, on the presumption that this would lead to increased employment but with little regards for the negative health consequences (Benach et al., 2014). Such policy responses, even while being promoted by the IMF, contradict the Fund's own recent recognition of the importance to protect social spending in countries under structural adjustment. Some of its recent working papers have argued for stronger collective labour bargaining power and increased public sector spending to stimulate the demand-side of persisting sluggish economic growth (Jaumotte and Osorio, 2015), while questioning the empirical basis for neoliberalism's economic

assumptions (Ostry et al., 2016).

4. Health equity implications of post-crisis austerity

The health and health equity effects of recessions have long been a subject of intense debate in public health, with inconclusive findings. On the one hand, some research has found that recessions in market economies are not associated with health decline but with health improvement, if measured at the aggregate level in terms of general mortality and major causes of death (Lin, 2009); while a healthy economy can actually undermine certain health outcomes (Ruhm, 2007). The health gains associated with recessions are explained in reference to changes in dietary habits and lifestyle choices, including more time to exercise, less exposure to hazardous working conditions, and healthier dietary choice due to loss of income (Ruhm, 2000). Similarly, some authors have suggested that health inequalities, if measured at the aggregate level in terms of socioeconomic inequality in mortality, might be procyclical in nature, that is, they tend to decline in recessions and increase during economic boom times (Valkonen et al., 2000). Following this, Ruhm has predicted that the health impacts of the global financial crisis and ensuing austerity will follow such a trajectory, and has pointed to (if minor) increases in Life Expectancy at Birth (LEB) even in crisis-stricken countries (Ruhm, 2015).

On the other hand, when assessing health and health equity more broadly using multiple indicators, and measuring health outcomes at the individual level, authors have long observed the health challenges that recessions can present, especially in terms of its mental health impacts and via deteriorating social determinants of health, such as a rise in unemployment (Suhrcke and Stuckler, 2012). Similarly, while little research has been conducted on the health equity impacts of recessions from a broader social determinants of health perspective, some studies do find evidence for unequal health impacts for different socio-economic groups in society. Edwards (2008), for example, finds that individuals with low levels of education (presumably translating into low wages) were at risk of declining health, while those with a high-school degree improved their health outcomes in the 1980s and 1990s during periods of rising unemployment. In addition, we expect the impact of the global financial crisis to be much longer lasting than the health effects of normal recessions which, especially in high-income countries, are, or can be, ameliorated by initial counter-cyclical government spending (Suhrcke and Stuckler, 2012). But the brief period of country-cyclical spending following the 2008 financial crisis quickly gave way to implementation of synchronized world-wide austerity around 2010, as noted above. This implies that any existing short-term, average and aggregate positive health effects linked to stimulus spending are likely to be more than offset by adverse long term health effects for individuals.

Our discussion below moves beyond simplistic assessments of the health equity impacts of austerity through a single statistical indicator, to focus on pathways which, directly and indirectly, connect austere fiscal policy with health equity relevant individual behaviours and structural outcomes, including: access to health services; loss of employment and its links to mental health; and the rise in labour market flexibility and associated precarious employment (WHO Commission on Social Determinants of Health, 2008). A central pathway that connects austerity to health equity is the restructuring of health services. In a recent narrative review of the impacts of post-crisis austerity on health in high-income countries, the authors found that spending cuts to health services often shifted the financial burden to households, increasing the cost of care, for example for drugs or via copayments, and reducing provision, such as closing or limiting operating hours of facilities or by staff layoffs (Karanikolos et al., 2016). Other studies have noted

that unmet health care need progressively increased in countries under the yoke of austerity, notably in Greece between 2008 and 2012 (Kentikelenis et al., 2014; Kentikelenis and Papanicolas, 2011). One survey in the United States found that 63 percent of all patients with chronic conditions reported economic barriers to accessing primary care in 2010, a significant uptick from before the financial crisis (Pearlman et al., 2012). Another study from the United States found that job loss during the recession widened health inequities as it increased the probability of unmet health needs by 4% in families with higher income, compared to more than 6% for families with lower income (Berger et al., 2011). Such findings are not surprising given that, for example in the case of Greece, steep health budget cuts led to clinic closures, job loss for over 37,000 public health workers and shortages in hospital medicines and supplies (Stuckler and McKee, 2012).

A WHO study documents that several European countries similarly reported steep cuts to health care budgets as part of post-crisis austerity, including Bulgaria, Romania, the Czech Republic, Estonia, Ireland, Latvia, Spain, and Portugal, in some cases in excess of 20 percent (World Health Organization, 2012). Several countries also instituted user charges for health services to address revenue shortfalls, including the Czech Republic, Denmark, Estonia, Finland, France, Greece, Ireland, Latvia, The Netherlands, Portugal, Romania and Turkey (Ruckert et al., 2015). Even in countries not under an IMF agreement, austerity is leaving a mark on healthcare. Italy, for instance, levied some novel user fees, pushed through parliament by decree by the technocratic care-taker government of Mario Monti, requiring patients to pay an extra €10 for medical consultations and a €25 fee for non-emergency care at hospitals (Houston et al., 2011). These healthcare fees are charged irrespective of the income of the patient, undermining the equitable provision of healthcare and potentially worsening income inequalities (Ruckert et al., 2015). Considering the more indirect health effects of welfare state contraction, previous studies suggest that, whilst overall population health is largely unaffected if measured at the aggregate level, inequalities in both mortality and morbidity increase when welfare services are cut (Bambra et al., 2015). Such negative health equity effects are further amplified by cutbacks to food subsidies, one of the key elements of austerity in developing countries, despite such subsidies often being the only way vulnerable populations can afford healthy food. But food subsidies have also been associated with enhanced nutritional status of disadvantaged families in high income countries, with food subsidy programs considered a central strategy to promote healthy nutrition and to reduce socio-economic inequalities in health (Black et al., 2012). In the case of the UK, a recent study found a significant rise in food emergency assistance (provided by food banks) which it associated with austerity measures (Loopstra et al., 2015). Rising food insecurity is an urgent health problem with an equity dimension, as it is not only strongly associated with malnutrition, but with inequitable mental health (Heflin et al., 2005) and chronic disease outcomes (Seligman and Schillinger, 2010), and deteriorating child health (Kirkpatrick et al., 2010).

Amongst the most documented negative impacts of austerity (at least in the short term) are those on mental health. Loss of income and unemployment are two of the crucial pathways by which austerity affects mental health, with historical evidence demonstrating that fiscal consolidation is much more likely to contract economic activity, lower aggregate demand and result in higher unemployment (Ortiz and Cummins, 2013). A recent study on trends in mental health inequities in England covering the period surrounding the Great Recession (from 2000 to 2013) found that the prevalence of mental health problems increased markedly during this era, with increases greatest in people with less education and amongst those out of work. It also suggests that austerity

measures and associated cutbacks in welfare provision may have contributed to this effect (Barr et al., 2015). Another study conducting a cross-sectional analysis of the Canadian Community Health Survey, during the period 2007 to 2013, observed significant increased odds of self-reported poor mental health, including a rise in mood and anxiety disorders (Nour et al., 2016); while yet another study observed an inequitable upward trend in the prevalence of suicide in Greece following the globally orchestrated austerity drive, with males in their 40s–80s most strongly affected (Antonakakis and Collins, 2014). It is not surprising that social protection spending seems to mitigate and equalize the negative mental health effects of recessions, with one recent study discovering that higher spending on active labour market programmes in 18 European countries was related to narrower inequality in depressive symptoms by education level (Niedzwiedz et al., 2016).

A final pathway that connects austerity to poor mental health is the rise in homelessness linked to economic decline and cutbacks in welfare provisioning. A recent study notes that each 10% fall in economic activity is associated with an increase of 0.45 homelessness claims per 1000 households, while increasing rates of homelessness were also strongly linked with government reductions in welfare spending (Loopstra et al., 2016b). While much of academic attention has been devoted to the immediate link between austerity, unemployment and deteriorating mental health, particularly the spiking of depression and suicide risks, some studies have also highlighted the potential long-term health implications of protracted unemployment (Milner et al., 2013). Such negative health findings in countries that underwent austerity contrast with health outcomes in countries that did not undertake such measures, especially when assessing self-reported health. For example, in Greece the prevalence of good self-rated health declined from 71 percent in 2006 to 68.8 percent in 2011, while in Iceland (which did not accept austerity measures) there was no significant change in self-reported health outcomes in the direct aftermath of the crisis (between 2007 and 2009) (Karaniolos et al., 2016).

Labour market flexibilization is a central aspect of the global austerity regime, with significant health implications (Benach et al., 2014). The policy responses to the GFC emphasize the importance of ‘modernizing’ labour markets, especially in developed economies struggling with large budget deficits. In most cases, this meant dismantling the protective measures that insulated workers from the vagaries of unregulated labour markets at a time when workers need such protections the most. A UNICEF review found that between 2008 and March 2012, 40 countries implementing SAPs altered their employment protection regulations for permanent employees, mainly by modifying the regulation of severance payments and notice periods; 25 countries also changed their legislation on collective dismissals by either facilitating the process or reducing requirements. Such measures are argued by the IFIs to enhance economic performance, by reducing unemployment (Bernal-Verdugo et al., 2012). However, evidence suggests that, in a context of economic contraction, labour market flexibility is more likely to lead to precarious and vulnerable employment, as well as depress domestic incomes and aggregate demand, ultimately hindering crisis recovery efforts (Ortiz and Cummins, 2013). The proliferation of precarious employment has raised strong concerns amongst population health researchers. Workers in precarious arrangements often share similar characteristics with the unemployed, with some evidence suggesting that chronic job insecurity may be more health damaging than actual job loss (Ruckert and Labonté, 2012). Effects which are typically, but not exclusively, related to precarious work arrangements, such as job insecurity, have long been linked to adverse health outcomes such as psychosocial morbidity (Ferrie et al., 2002).

Finally there are concerns in the population health community that welfare reform which is implemented in many countries as part of the austerity drive, and generally amounts to cutbacks either by reducing welfare payments outright or by changing eligibility criteria, could compromise the health of the elderly. And indeed a recent study linked austerity driven reductions in income support and social care for low-income seniors in the UK to rising mortality rates among pensioners aged 85 years and over, with each 1% drop in support for low income pensioners associated with an increase in 0.68% in old-age mortality (Loopstra et al., 2016a). Another qualitative study found that removal of a housing subsidy (also known as the ‘bedroom tax’) in the UK has undermined purchasing power for essentials among vulnerable populations, particularly for food and utilities, with study participants recounting negative impacts on mental health, family relationships and community networks (Moffatt et al., 2016).

5. Conclusion: the need for strong social protection policies

In many ways, it is still too early to assess the full health equity impacts of the global austerity regime, as few studies have been conducted on the topic to date, with existing studies largely focused on the health effects of austerity in high income countries and a lack of research originating in lower income settings; and because it will take time for the longer term health (equity) effects to become fully visible and measurable (Bambra et al., 2015). However, it is clear that the impact of the crisis and ensuing austerity will be overall negative unless we internalize one key lesson: evidence from current and previous episodes of economic recession and implementation of austerity clearly demonstrate that health equity results are influenced by national policy variation. In particular, social protection spending has been found to be a key mitigating factor during times of economic downturn and episodes of austerity, especially for the most vulnerable in society (Copeland et al., 2015). The interaction of fiscal austerity with social protection policy should therefore be considered a central driving force of health equity outcomes (Karaniolos et al., 2013). Similarly, the adverse health effects of unemployment can be mitigated by strong labour market protections, especially through active labour market policies. This confirms findings in the literature on welfare state regimes which examines how between-country differences in health inequalities are related to variations in the provision of welfare (Stuckler et al., 2009), drawing on the institutional turn in social stratification scholarship (Beckfield et al., 2015).

Granting governments the fiscal space to engage in much-needed social protection spending requires reforming the dominant (unfair and unsustainable) global taxation regime which has for too long allowed multinational corporations and wealthy individuals to game the system and hide their income from taxation, undermining the fiscal capacity of the state to provide social protection from sudden and violent market movements. At the same time, global tax competition has substantially eroded the progressivity of tax regimes and the taxation (public revenue) share of GDP in most countries, with one study estimating that the untaxed monetized value of global economic product rose from USD 28 trillion in 2004 to USD 58 trillion in 2012 – more than doubling in only eight years (Labonté and Stuckler, 2016). There are increasing calls to increase taxation, albeit more to support public spending to increase aggregate demand than to begin reversing the massive upwards flow of wealth that has characterized the past 40 years of neoliberal economic dominance. Even as some low-income country governments are attempting to increase their domestic revenue generation, a combination of a legacy of tax holidays to attract foreign investment, illicit capital flight, high unemployment rates, and low GDP means that many countries will be unable to self-

finance sufficient social protection measures. This fiscal shortfall has led to many observers and the International Labour Organization (ILO), amongst other multilaterals and non-governmental organization, to call for establishment of a Global Social Protection Fund that would help finance national social protection floors (International Labour Organization, 2012). Such a floor would be based upon nationally defined sets of basic social security guarantees that included, as a minimum, universal access to essential health care and basic income security. There is already international agreement that financial assistance should be provided to nations unable to self-finance such floors, and an existing (if hitherto largely unused) funding mechanism (the World Solidarity Fund, created by the UN General Assembly in 2002) that could be used for this purpose (Cichon, 2015).

The world's governments once again iterated this commitment as part of the post-2015 Sustainable Development Goals (SDGs), with one of the poverty reduction targets being “nationally appropriate social protection systems and measures for all, including floors” by 2030. The SDGs in their indivisible totality represent a compelling anti-austerity agenda, with 17 goals articulating a fundamentally different vision of the world we presently inhabit. The SDGs have many flaws and one basic contradiction: the assumption that the ‘business-as-usual’ and still largely neoliberal global economic growth model will somehow lead to greater income equality and a livable ecology. It can't and it won't; the evidence on that is irrefutable (Sustainability Commission, 2015). But an advocacy focus on those SDGs that are central to promoting a more equitable global health (and one that is environmentally sustainable) hold some potential to surround the neoliberal economic model with policies and regulations that undermine its power and its legitimacy. A recent consolidation of those goals created a priority list of seven: end poverty, end hunger, ensure healthy lives, ensure quality education, ensure sustainable water and sanitation for all, reduce inequality, and ensure (environmentally) sustainable consumption and production (Labonté, 2016). Achievement of many of the other SDGs are implicit in accomplishing these seven, which can even be shortened to just three: quality education, reduce inequality, and environmentally sustainable consumption and production.

Even so, moving forward on the idealistic intent of the SDGs will require massive forms of income redistribution within and between nations, as estimates of the costs of achieving the 169 targets of the SDGs are in multiples of trillions (the most commonly cited being USD 3 trillion annually) that governments still under the thrall of austerity are reluctant to finance. Yet a simple mechanism exists (a financial transaction tax) that, if applied at a negligible rate of 0.05 percent (5 cents per every 100 dollars) and to derivatives as well as more conventional forms of currency exchanges, could raise over USD 8.6 trillion annually (McCulloch and Pacillo, 2011) – more than enough to finance the SDGs through such mechanisms as the global health funds (or the proposed and less disease-specific, Global Fund for Health), the Green Climate Fund and the proposed Global Social Protection Fund. Regrettably, reference to a global financial transaction tax was removed from the final version of the SDGs, undoubtedly to placate those countries with a vested interest in footloose global capital and opposed to such a tax.

Finally, to advance a global progressive agenda will also require considerable activism at the national government level, as most governments have yet to act upon any of the SDGs. At minimum, and whenever encountered in public policy regardless of how such policies might be packaged, it is imperative that neoliberal economic orthodoxy and its austerity regime be vociferously challenged for its lack of any theoretical, empirical or ethical justification. The recent election of Donald Trump in the United States and the decision by voters in the United Kingdom to leave the

European Union (both outcomes by the slimmest of political margins) might open a window of opportunity to reorganize the global neoliberal order in ways more supportive of the health and equity-oriented social and ecological dimensions of the SDGs. But the protectionist and nationalist rhetoric that spurred these 2016 electoral shocks, and the divisive xenophobia, racism and misogyny that were most pronounced in the Trump campaign, are hardly healthy alternatives to a potentially weakened neoliberal order. Instead, what is needed is a clear articulation of an inclusive left-populist platform that challenges the rise of the ‘alt-right’ (alternative right), by addressing the anger and concerns of the voters who expressed their clear disaffection with the politics and economics that have predominated over the past 40 years.

Conflict of interest statement

We have no conflict of interest to declare.

Acknowledgements:

We would like to acknowledge financial support from the Canadian government through the Canada Research Chair program.

References

- Antonakakis, N., Collins, A., 2014. The impact of fiscal austerity on suicide: on the empirics of a modern Greek tragedy. *Soc. Sci. Med.* 112, 39–50. <http://dx.doi.org/10.1016/j.socscimed.2014.04.019>.
- Bambra, C., Garthwaite, K., Copeland, A., Barr, B., 2015. All in it together? Health inequalities, austerity, and the “Great Recession.”. In: Smith, K.E., Bambra, C., Hill, S.E. (Eds.), *Health Inequalities*. Oxford University Press, Oxford, pp. 164–176.
- Banoob, S.N., 2009. Minimizing the health impacts of the global financial crisis. *J. Public Health Policy* 30, 243–247. <http://dx.doi.org/10.1057/jphp.2009.18>.
- Barr, B., Kinderman, P., Whitehead, M., 2015. Trends in mental health inequalities in England during a period of recession, austerity and welfare reform 2004 to 2013. *Soc. Sci. Med.* 147, 324–331. <http://dx.doi.org/10.1016/j.socscimed.2015.11.009>.
- Beckfield, J., Bambra, C., Eikemo, T.A., Huijts, T., McNamara, C., Wendt, C., 2015. An institutional theory of welfare state effects on the distribution of population health. *Soc. Theory Health* 13, 227–244. <http://dx.doi.org/10.1057/sth.2015.19>.
- Benach, J., Vives, A., Amable, M., Vanroelen, C., Tarafa, G., Muntaner, C., 2014. Precarious employment: understanding an emerging social determinant of health. *Annu. Rev. Public Health* 35, 229–253. <http://dx.doi.org/10.1146/annurev-publichealth-032013-182500>.
- Benatar, S.R., Gill, S., Bakker, I., 2011. Global health and the global economic crisis. *Am. J. Public Health* 101, 646–653. <http://dx.doi.org/10.2105/AJPH.2009.188458>.
- Berger, R.P., Fromkin, J.B., Stutz, H., Makoroff, K., Scribano, P.V., Feldman, K., Tu, L.C., Fabio, A., 2011. Abusive head trauma during a time of increased unemployment: a multicenter analysis. *Pediatrics* 128, 637–643.
- Bernal-Verdugo, L.E., Furceri, D., Guillaume, D., 2012. Labor market flexibility and unemployment: new empirical evidence of static and dynamic effects. *Comp. Econ. Stud.* 54, 251–273.
- Bhattacharya, D., Moyo, T., Terán, J.F., Morales, L.I.R., Lóránt, K., Graham, Y., Anyemedu, K., Makokha, K.A., Mihevc, J., Nacpil, L., 2002. The policy roots of economic crisis and poverty: a multi-country participatory assessment of structural adjustment. *Wash. D.C. Struct. Particip. Rev. Int. Netw. SAPRIN Secr.* [WWW Document], http://www.saprin.org/SAPRIN_Findings.pdf, (Accessed 11 November 2016).
- Black, A.P., Brimblecombe, J., Eyles, H., Morris, P., Vally, H., O’Dea, K., 2012. Food subsidy programs and the health and nutritional status of disadvantaged families in high income countries: a systematic review. *BMC Public Health* 12, 1099. <http://dx.doi.org/10.1186/1471-2458-12-1099>.
- Cichon, M., 2015. A Global Fund for Social Protection Floors: Eight Good Reasons Why it Can Easily Be Done | News & Views | UNRISD [WWW Document]. [http://www.unrisd.org/UNRISD/website/newsview.nsf/\(httpNews\)/534394C84B10238AC1257E76004D04F9?OpenDocument](http://www.unrisd.org/UNRISD/website/newsview.nsf/(httpNews)/534394C84B10238AC1257E76004D04F9?OpenDocument) (accessed 11 October 2016).
- Copeland, A., Bambra, C., Nylén, L., Kasim, A., Riva, M., Curtis, S., Burström, B., 2015. All in it together? The effects of recession on population health and health inequalities in England and Sweden, 1990–2010. *Int. J. Health Serv. Plan. Adm. Eval.* 45, 3–24.
- Edwards, R., 2008. Who is hurt by procyclical mortality? *Soc. Sci. Med.* 67, 2051–2058.
- Ferrie, J., Shipley, M., Stansfeld, S., Marmot, M., 2002. Effects of chronic job insecurity and change in job security on self reported health, minor psychiatric morbidity, physiological measures, and health related behaviours in British civil

- servants: the Whitehall II study. *J. Epidemiol. Community Health* 56, 450–454. <http://dx.doi.org/10.1136/jech.56.6.450>.
- Heflin, C.M., Siefert, K., Williams, D.R., 2005. Food insufficiency and women's mental health: findings from a 3-year panel of welfare recipients. *Soc. Sci. Med.* 1982 (61), 1971–1982. <http://dx.doi.org/10.1016/j.socscimed.2005.04.014>.
- Houston, M., Day, M., Lago, M. de, Zarocostas, J., 2011. Health services across Europe face cuts as debt crisis begins to bite. *BMJ* 343. <http://dx.doi.org/10.1136/bmj.d5266>.
- International Labour Organization, 2012. Recommendation R202-social Protection Floors Recommendation, 2012 (No. 202) [WWW Document]. http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:3065524 (accessed 5 October 2016).
- Jaumotte, M.F., Osorio, M.C., 2015. Inequality and Labor Market Institutions. International Monetary Fund, Washington DC.
- Karanikolos, M., Heino, P., McKee, M., Stuckler, D., Legido-Quigley, H., 2016. Effects of the global financial crisis on health in high-income oecd countries a narrative review. *Int. J. Health Serv.* 46, 208–240.
- Karanikolos, M., Mladovsky, P., Cylus, J., Thomson, S., Basu, S., Stuckler, D., Mackenbach, J.P., McKee, M., 2013. Financial crisis, austerity, and health in Europe. *Lancet* 381, 1323–1331.
- Kentikelenis, A., Karanikolos, M., Reeves, A., McKee, M., Stuckler, D., 2014. Greece's health crisis: from austerity to denialism. *Lancet* 383, 748–753.
- Kentikelenis, A., Papanicolas, I., 2011. Economic crisis, austerity and the Greek public health system. *Eur. J. Public Health* 22, 4–5.
- Kirkpatrick, S.I., McIntyre, L., Potestio, M.L., 2010. Child hunger and long-term adverse consequences for health. *Arch. Pediatr. Adolesc. Med.* 164, 754–762. <http://dx.doi.org/10.1001/archpediatrics.2010.117>.
- Labonté, R., 2016. Health promotion in an age of normative equity and rampant inequality. *Int. J. Health Policy Manag.* 12 (5), 675–682.
- Labonté, R., 2009. The global financial crisis and health: scaling up our effort. *Can. J. Public Health Rev. Can. Santé Publique* 100, 173–175.
- Labonté, R., Stuckler, D., 2016. The rise of neoliberalism: how bad economics imperils health and what to do about it. *J. Epidemiol. Community Health* 70, 312–318. <http://dx.doi.org/10.1136/jech-2015-206295>.
- Lawson, M., 2016. The World Bank and Inequality: from Poverty to Power. <http://oxfamblogs.org/fp2p/talk-is-cheap-but-will-the-world-bank-really-step-up-on-inequality/> (accessed 02 March 2016).
- Lin, S.-J., 2009. Economic fluctuations and health outcome: a panel analysis of Asia-Pacific countries. *Appl. Econ.* 41, 519–530.
- Loopstra, R., McKee, M., Katikireddi, S.V., Taylor-Robinson, D., Barr, B., Stuckler, D., 2016a. Austerity and old-age mortality in England: a longitudinal cross-local area analysis, 2007–2013. *J. R. Soc. Med.* 109, 109–116. <http://dx.doi.org/10.1177/0141076816632215>.
- Loopstra, R., Reeves, A., Barr, B., Taylor-Robinson, D., McKee, M., Stuckler, D., 2016b. The impact of economic downturns and budget cuts on homelessness claim rates across 323 local authorities in England, 2004–12. *J. Public Health* 38, 417–425. <http://dx.doi.org/10.1093/pubmed/fdv126>.
- Loopstra, R., Reeves, A., Taylor-Robinson, D., Barr, B., McKee, M., Stuckler, D., 2015. Austerity, sanctions, and the rise of food banks in the UK. *BMJ* 350, h1775.
- Marmot, M.G., Bell, R., 2009. How will the financial crisis affect health? *b1314 BMJ* 338, b1314. <http://dx.doi.org/10.1136/bmj.b1314>.
- McBride, S., Mahon, R., Boychuk, G.W., 2016. *After '08: Social Policy and the Global Financial Crisis*. UBC Press, Vancouver.
- McCulloch, N., Pacillo, G., 2011. The Tobin tax: a review of the evidence, 2011 IDS Res. Rep. 1–77.
- McIntyre, D., Thiede, M., Dahlgren, G., Whitehead, M., 2006. What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts? *Soc. Sci. Med.* 62, 858–865. <http://dx.doi.org/10.1016/j.socscimed.2005.07.001>.
- Milner, A., Page, A., LaMontagne, A.D., 2013. Long-term unemployment and suicide: a systematic review and meta-analysis. *PLoS One* 8, e51333. <http://dx.doi.org/10.1371/journal.pone.0051333>.
- Moffatt, S., Lawson, S., Patterson, R., Holding, E., Dennison, A., Sowden, S., Brown, J., 2016. A qualitative study of the impact of the UK "bedroom tax." *J. Public Health* 38, 197–205. <http://dx.doi.org/10.1093/pubmed/fdv031>.
- Niedzwiedz, C.L., Mitchell, R.J., Shortt, N.K., Pearce, J.R., 2016. Social protection spending and inequalities in depressive symptoms across Europe. *Soc. Psychiatry Psychiatr. Epidemiol.* 51, 1005–1014. <http://dx.doi.org/10.1007/s00127-016-1223-6>.
- Nour, S., Labonté, R., Bancej, C., 2016. Impact of the 2008 global financial crisis on the health of Canadians: repeated cross-sectional analysis of the Canadian Community Health Survey, 2007–2013. *J. Epidemiol. Community Health* 71, 336–343. <http://dx.doi.org/10.1136/jech-2016-207661>.
- Ortiz, I., Cummins, M., 2013. The Age of Austerity: a Review of Public Expenditures and Adjustment Measures in 181 Countries. Available SSRN 2260771.
- Ortiz, I., Cummins, M., Capaldo, J., Karunanethy, K., 2015. The Decade of Adjustment: a Review of Austerity Trends 2010–2020 in 187 Countries [WWW Document]. <http://www.social-protection.org/gimi/gess/RessourcePDF.action?ressource.ressourceId=53192> (accessed 10 January 2017).
- Ostry, J.D., Loungani, P., Furceri, D., 2016. Neoliberalism Oversold. *Finance Dev.* 53, 38–41.
- Pearlman, D.N., Jackson, T.L., Gjelsvik, A., Viner-Brown, S., Garro, A., 2012. The impact of the 2007–2009 US recession on the health of children with asthma: evidence from the national Child Asthma Call-Back Survey. *Med. Health R. I.* 95, 394–396.
- Ruckert, A., Labonté, R., 2012. The global financial crisis and health equity: toward a conceptual framework. *Crit. Public Health* 22, 267–279.
- Ruckert, A., Labonté, R., 2012. The financial crisis and global health: the International Monetary Fund's (IMF) policy response. *Health promot. Int.* 22, 267–279.
- Ruckert, A., Labonté, R., Parker, R.H., 2015. Global healthcare policy and the austerity agenda. In: Kuhlmann, E., Blank, R.H., Bourgeault, I.L., Wendt, C. (Eds.), *The Palgrave International Handbook of Healthcare Policy and Governance*. Palgrave Macmillan UK, London, pp. 37–53.
- Ruhm, C.J., 2015. Health Effects of Economic Crises. National Bureau of Economic Research.
- Ruhm, C.J., 2007. A healthy economy can break your heart. *Demography* 44, 829–848.
- Ruhm, C.J., 2000. Are recessions good for your health? *Q. J. Econ.* 115, 617–650.
- Seligman, H.K., Schilling, D., 2010. Hunger and socioeconomic disparities in chronic disease. *N. Engl. J. Med.* 363, 6–9. <http://dx.doi.org/10.1056/NEJMp1000072>.
- Stuckler, D., Basu, S., Suhrcke, M., McKee, M., 2009. The health implications of financial crisis: a review of the evidence. *Ulst. Med. J.* 78, 142–145.
- Stuckler, D., McKee, M., 2012. There is an alternative: public health professionals must not remain silent at a time of financial crisis. *Eur. J. Public Health* 22, 2–3. <http://dx.doi.org/10.1093/eurpub/ckr189>.
- Suhrcke, M., Stuckler, D., 2012. Will the recession be bad for our health? It depends. *Soc. Sci. Med.* 74, 647–653.
- Sustainability Commission, 2015. Sustainability Commission Report [WWW Document]. <http://www.birmingham.ac.uk/Documents/college-eps/energy/policy/ipt-sustainability-commission-report-update.pdf> (accessed 11 October 2016).
- Valkonen, T., Martikainen, P., Jalovaara, M., Koskinen, S., Martelin, T., Mäkelä, P., 2000. Changes in socioeconomic inequalities in mortality during an economic boom and recession among middle-aged men and women in Finland. *Eur. J. Public Health* 10, 274–280. <http://dx.doi.org/10.1093/eurpub/10.4.274>.
- WHO Commission on Social Determinants of Health, 2008. Closing the Gap in a Generation Health Equity through Action on the Social Determinants of Health: Commission on Social Determinants of Health Final Report. World Health Organization, Geneva.
- Williamson, J., 2004. The strange history of the Washington consensus. *J. Post. Keynes. Econ.* 27, 195–206.
- World Health Organization, 2012. Policy Summary 5: Health Policy Responses to the Financial Crisis in Europe [WWW Document]. http://www.euro.who.int/_data/assets/pdf_file/0009/170865/e96643.pdf (accessed 5 October 2016).